

Department of State Health Services
Certificate of Record for Vision Screen and/or Eye Examination

ATTENTION PARENT: The Vision and Hearing Screening Program requires that every child have an eye examination or an approved vision screening test prior to or within 120 days after entry into a Texas public or private preschool or school, licensed child care center, or child care home.

Child's Name _____ Birthdate _____ Age _____

The tests conducted to evaluate your child's vision are screens; they are not diagnostic. This means that if your child fails a screen, it is necessary for him or her to be evaluated by his or her primary care provider to determine whether there is a vision problem. It also means that on some occasions a vision problem may exist that the screens will not identify.

VISION SCREENER REPORT		
DISTANCE ACUITY SCREEN:		
1st Screen: Date _____ With Correction: <input type="checkbox"/> Yes <input type="checkbox"/> No Chart Used: Letter <input type="checkbox"/> Rt Eye 20/___ <input type="checkbox"/> Lft Eye 20/___ "E" <input type="checkbox"/> Rt Eye 20/___ <input type="checkbox"/> Lft Eye 20/___ HOTV <input type="checkbox"/> Rt Eye 20/___ <input type="checkbox"/> Lft Eye 20/___ Autom. Screening Device _____ <input type="checkbox"/> PASS <input type="checkbox"/> FAIL	2nd Screen: Date _____ With Correction: <input type="checkbox"/> Yes <input type="checkbox"/> No Chart Used: Letter <input type="checkbox"/> Rt Eye 20/___ <input type="checkbox"/> Lft Eye 20/___ "E" <input type="checkbox"/> Rt Eye 20/___ <input type="checkbox"/> Lft Eye 20/___ HOTV <input type="checkbox"/> Rt Eye 20/___ <input type="checkbox"/> Lft Eye 20/___	Comments/Observations:
HIRSCHBERG CORNEAL	COVER AND UNCOVER	
Light Reflex Test <input type="checkbox"/> Light reflection is centered or slightly toward the nose the same distance in each eye. <input type="checkbox"/> Light reflection is not centered nor slightly toward the nose the same distance in each eye. <input type="checkbox"/> PASS <input type="checkbox"/> FAIL	NEAR: 12 to 13 inches <input type="checkbox"/> No Eye Movement <input type="checkbox"/> Eye Movement <input type="checkbox"/> PASS <input type="checkbox"/> FAIL	FAR: 10 to 20 feet <input type="checkbox"/> No Eye Movement <input type="checkbox"/> Eye Movement <input type="checkbox"/> PASS <input type="checkbox"/> FAIL
Referral to a primary care provider due to:		
<input type="checkbox"/> Distance Acuity Test <input type="checkbox"/> Hirschberg Corneal Light Reflex Test <input type="checkbox"/> Cover and Uncover Test	<input type="checkbox"/> Observable Signs or Symptoms _____ (describe) _____ <input type="checkbox"/> Parent/Doctor Request	<input type="checkbox"/> Other: _____ _____ <input type="checkbox"/> UNSCREENABLE
Date of Final Screen: _____	Name of Screener (please print): _____	
Signature of Screener: _____		

***** WAIVER OF REFERRAL *****

My child _____ is being seen by an eye care specialist, _____ (doctor's name), for the problem(s) indicated.

Parent's Signature _____ Date _____

Revised 8/2014

INDIVIDUAL SWEEP-CHECK SCREENING (M-40)

Student's name: _____ Birth date: _____

School: _____ Grade: _____ Teacher: _____

Sweep-Check Screening

1. Instruct and condition each child appropriately for age/grade.
2. Screen three frequencies at 25 dB; begin screening at 1000 Hz.
3. Identify responses with a "+"; identify no response with a "-."
4. Sequence of tone presentations is numbered 1-3 below.

	Ear	1	2	3	Results
		1000 Hz	2000 Hz	4000 Hz	
First Screen:	R				<input type="checkbox"/> Pass <input type="checkbox"/> Rescreen w/Sweep
Date:	L				

Comments: _____

Signature of Screener: _____ Print Name _____

Children failing to respond to **ONE** (of the three) frequencies in **EITHER EAR** should be rescreened with another sweep-check within three to four weeks. (Signs or symptoms alone would be sufficient for referral.) Failure of **ONE** frequency in either ear on the second sweep-check screen requires a referral or an **Extended Recheck**. If a failure of one frequency occurs when performing the extended recheck, a referral is required.

	Ear	1	2	3	Results
		1000 Hz	2000 Hz	4000 Hz	
Second Screen:	R				<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Date:	L				

Comments: _____

Signature of Screener: _____ Print Name _____

Extended Recheck Results

For each of the three frequencies listed, starting at 40 dB, record the lowest level in decibels (dB) at which the child responds. Record the findings for both the right and left ears. A child should be referred to an appropriately licensed professional if any one of the three frequencies is recorded as greater than 25 dB in either ear.

	Ear	1	2	3	Results
		1000 Hz	2000 Hz	4000 Hz	
	R	dB	dB	dB	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Date:	L	dB	dB	dB	

Comments: _____

Signature of Screener: _____ Print Name _____