Cook County
Department of Public Health
Vision-Hearing Screening

School Dwight D. Eisenhower **Teacher** BERNSTEIN **Grade** 2
Last Name [redacted] **First Name** [redacted]
Mailing Name [redacted]
Address 208 [redacted]
Birth Date 3/2/1998 **Gender** M

Technician: _____ **Date:** _____

MUSCLE BALANCE
Near In_____ Out_____
Far In_____ Out_____

_____Passed
_____Passed rescreen on_____
_____Refered on_____
_____Wearing glasses
_____Wearing contact lenses
_____Under doctor's care

ACUITY
Right 0 1 2 3 4 5 6
Left 0 1 2 3 4 5 6

HYPEROPIA
Right 0 1 2 3 4 5 6
Left 0 1 2 3 4 5 6

Name of Eye Doctor:
_____
Date of last eye exam:
_____
Observable symptoms:
_____
Color Screening:
_____ of 8 Pass / Fail

BRL
Near _____/_____/_____
Far _____/_____/_____

Technician: _____ Date: _____

Screening

Passed_____
Failed_____

Rescreened

Passed _____
Threshold_____
Referral_____ Non ref_____
Monitor_____ H.A._____