

# Hearing and Vision Screening Teacher Referral

Complete the following information for the student referred for a hearing and/or vision screening. Submit the completed form to your building Nurse who will forward the request to the Health Assistant for scheduling.

Student: \_\_\_\_\_

Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_

Date: \_\_\_\_\_

Screening Requested:      Hearing                  Vision                  Both

Send Results To: \_\_\_\_\_