_____ _____ Grade_____

VISION AND HEARING PROGRAM CONSENT FORM

Your child is scheduled to be screened for **Vision and Hearing by the Whiteside County Health Department(WCHD).** The information below is requested.

Child's Name_____ _____ Birth date ____/____/____ Age_____
(Last) (First) (MI)

Address _____ Guardian's Name_____ Phone_____
(Street) (City) (Zip Code)

Is your child on Medicaid? Yes No Please provide Medicaid number_____

1. Does your child see an eye doctor on a regular basis or need glasses/contacts now or has had them in the past? .....Yes No

2. Has your child had a hearing test recently?..... Yes No

DO NOT WRITE BELOW

	P	F		P	F	R	CNT	FNR		P	F		P	F	R	CNT	FNR
Hearing (1)	{ }	{ }	(2)	{ }	{ }	{ }	{ }	{ }	Vision (1)	{ }	{ }	(2)	{ }	{ }	{ }	{ }	{ }

Comments: _____
mferr11/10

School_____ _____ Grade_____

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Hearing (1)	{ }	{ }	(2)	{ }	{ }	{ }	{ }	{ }	Vision (1)	{ }	{ }	(2)	{ }	{ }	{ }	{ }	{ }

Comments: _____
mferr11/10