Scheduling form for Vision/Hearing

School District____________________ School_____________________

Contact Person: ___________________ Phone: __________ Email: ___________

Start time: ___________ End Time: ___________ Date of Screening: ___________

Students with Magnetic programmable shunts? Y  N Name _____________ Grade____

Pre-K NUMBER OF STUDENTS (per classroom):
Screening for both Hearing & Vision

PRE-K_______ AM/PM M T W TH F PRE-K_______ AM/PM M T W TH F
PRE-K_______ AM/PM M T W TH F PRE-K_______ AM/PM M T W TH F
PRE-K_______ AM/PM M T W TH F PRE-K_______ AM/PM M T W TH F
PRE-K_______ AM/PM M T W TH F PRE-K_______ AM/PM M T W TH F

Young Fives ____________AM/PM M T W TH F (Any type of junior kindergarten, Kick start, etc.)
Young Fives ____________AM/PM M T W TH F

Total_________ Total_________

Start Time: ___________ End Time _____________

SCHOOL AGE SCREENINGS

Screening Vision 1st_______ 3rd_______ 5th_______
7th_______ 9th_______ Total_______

Screening Hearing K_______ 2nd_______ 4th_______ Total_______

FAX Back to: 269-673-4172
Email alocker@allegancounty.org or aarias@allegancounty.org
Allegan County Health Department