Learning on TAP

Vision and hearing screening for school-age children
Screen form

[Service provider logo]	Name of screener ✎
	Date of screen ✎
	Location ✎

1. Information about the child	
Family name ✎	Given names ✎
Date of birth ✎	Gender: Male ☐ Female ☐ Other ☐
Address ✎	
School ✎	Class ✎
Parent/caregiver details	
Family name ✎	Given names ✎
Phone/email ✎	Languages spoken ✎
Consent: Yes ☐ No ☐	

2. Pre-screening questions *Copy the information from the completed consent form.*			**Result**
Does the child wear spectacles? Yes ☐ No ☐	**Yes** → What are the spectacles used for?		**No** → Continue **Yes** and a **problem is identified** during screening ☞ **Refer** to eye care personnel at service child is already using ☐
	Seeing things in the distance	☐	→ Ask child to wear spectacles for screening ☐
	Seeing things that are near	☐	→ Ask child **not** to wear spectacles for screening ☐
	Do not know	☐	
Does the child wear hearing aids? Yes ☐ No ☐			**No** → Continue ☐ **Yes** and a **problem is identified** during screening ☞ **Refer** to ear care personnel at service child is already using ☐
Does the child have diabetes? Yes ☐ No ☐			**No** to **both** → Continue ☐ **Yes** to **either** ☞ **Refer** to eye care personnel ☐
Pain / discomfort / severe itchiness in their child's eye/s. Yes ☐ No ☐			
Concerns about child's vision? Yes ☐ No ☐			**No** to **both** → Continue ☐ **Yes** to **either** → Continue. If child passes arrange Follow up screen ☐
Concerns about child's hearing? Yes ☐ No ☐			

3. Distance vision screen			
Chart:	8 years and younger ☐ → HOTV Older than 8 years ☐→ E chart		
Spectacles:	If the child wears spectacles for distance vision, are they wearing them today?		Yes ☐ No ☐
Right eye: Top line	**Result**	**Right eye: Bottom line**	**Result**
Child matches **2 or more** letters correctly on the top line: Yes ☐ No ☐	**Yes** → Continue bottom line **No** → Continue Left eye	Child matches **3 or more** letters correctly on the bottom line: Yes ☐ No ☐	**Yes** to **both** → **Pass** ☐ **No** to **any** ☞ **Refer** ☐

Left eye: Top line	Result	Left eye: Bottom line	Result
Child matches **2 or more** letters correctly on the top line: Yes ☐ No ☐	**Yes** → Continue bottom line **No** → Continue Eye health screen	Child matches **3 or more** letters correctly on the bottom line: Yes ☐ No ☐	**Yes** to **both** → **Pass** ☐ **No** to **any** ☞ **Refer** ☐

4. Eye health screen *Look at each eye with torch.*			**Result**
Do **both** eyes look healthy? Yes ☐ No ☐	**No** → Why?		**Yes** → **Pass** ☐ **No** ☞ **Refer** ☐
	Crust or pus on eyelids/eyelashes	☐	
	Red colour on white of the eye	☐	
	Discharge from eye	☐	
	Coloured part of eye unclear/milky	☐	
	Eyes not looking in the same direction	☐	
	Other	☐	

5. Hearing screen										
Practice screen										**Result**
Does child hear sound at 1000Hz and 40dB?	Right ear: Yes ☐ No ☐ Left ear: Yes ☐ No ☐									**Yes** to **both** → **Pass** ☐ **No** to **any** ☞ **Refer** ☐ Stop hearing screen and → Continue to ear health screen.
Full screen										**Result**
	Tick if child hears 20 dB sound									**Two or more ticks** for each frequency for both ears → **Pass** ☐ **Less than two ticks** for any frequency for either ear ☞ **Refer** ☐
	1000 Hz			**2000 Hz**			**4000 Hz**			
Right ear	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Left ear	☐	☐	☐	☐	☐	☐	☐	☐	☐	

6. Ear health screen			
Outside of the ear *Look at each ear with eyes.*			**Result**
Do **both** ears look healthy? Yes ☐ No ☐	**No** → Why?		**Yes** → **Pass** ☐ **No** ☞ **Refer** ☐
	Damage / scars / injury	☐	
	Pinna or ear canal missing, or very different shape	☐	
	Swelling	☐	
	Change of colour	☐	
	Discharge	☐	
Does the child feel pain when you press the tragus?	Left: Yes ☐ No ☐		**No** to **both** → **Pass** ☐ **Yes** to **any** → Stop the ear health screen and ☞ **Refer** ☐
	Right: Yes ☐ No ☐		
Inside the ear (ear canal and eardrum) *Check each ear with otoscope.*			**Result**
Do **both** ears look healthy? Yes ☐ No ☐	**No** → Why?		**Yes** → **Pass** ☐ **No** ☞ **Refer** ☐
	Pain	☐	
	Swelling	☐	
	Redness	☐	
	Discharge	☐	
	Blocked (wax or foreign body)	☐	
	Damage / injury	☐	

	Other	☐	
Do **both** eardrums look healthy? Yes ☐ No ☐	**No** → Why?		**Yes** → **Pass** ☐ **No** ☞ **Refer** ☐
	Unable to see eardrum	☐	
	Swelling and/or redness on the eardrum	☐	
	Holes (perforations)	☐	

7. Plan		
Results	**Plan**	
Did not attend	Reschedule screening	☐
Passed all results	Inform parents of results using Notification form	☐
	Parent/caregiver has concerns	
	Discuss with parents	☐
	Arrange follow up screen	☐
Refer result for any: • Pre-screening questions • Vision screen • Eye health screen • Hearing screen • Ear health screen.	Discuss need to refer with parents/caregivers	☐
	Child already has spectacles or hearing aids	
	Ask parent/caregiver to take child to existing service provider	☐
	Send Notification form	☐
	Enter information into Follow up referral list	☐
	Share information with screening coordinator	☐