234 N. Gohmert St./P.O. Box 706
Yorktown, Texas 78164
(Phone) 361-564-9444
(Fax) 361-564-9222

Vision and Hearing Exam

Name of Child _____ Date of Birth _____

Health Care Professional Name: _____

Address: _____ City _____ State ____ Zip _____

Health Care Professional Signature: _____ Date _____

Vision Exam Results

Right Eye 20/_____ Left Eye 20/_____ ○ Pass ○ Fail

Health Care Professional Signature: _____ Date _____

Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				○ Pass ○ Fail
Left				○ Pass ○ Fail

Health Care Professional Signature: _____ Date _____

Parent Signature _____ Date _____