Name:_____ Psychologist:_____ Date:_____

School:_____ Grade:_____ Age:_____ Sex:_____

AUDIO

	(LEFT) 500	1000	2000	3000	4000		(RIGHT) 500	1000	2000	3000	4000	
0												0
10												10
20												20
25-----												-----25
30												30
40												40
50												50
60												60
70												70
80												80
90	500	1000	2000	3000	4000		500	1000	2000	3000	4000	90

VISION

NEAR POINT

(without glasses)	(with glasses)
LEFT 20/_____	20/_____
RIGHT 20/_____	20/_____
BOTH 20/_____	20/_____

COLOR BLIND:_____

FLASH CARDS:_____

FAR POINT

(without glasses)	(with glasses)
LEFT 20/_____	20/_____
RIGHT 20/_____	20/_____
BOTH 20/_____	20/_____

VERTICAL IMBALANCE:_____

LATERAL IMBALANCE:_____

COMMENTS:

APPROVED BY:_____

Student ___Passed Vision ___Failed Vision ___Passed Hearing ___Failed Hearing

Next Steps:_____

PSYCHOLOGICAL SERVICES #26 (REV. 12-03)

Signature of School Nurse _____