

CHILD'S NAME (LAST, FIRST, MI) \_\_\_\_\_

SPONSOR'S SS# LAST 4 (last name if different than child) \_\_\_\_\_

CHILD'S BIRTHDATE \_\_\_\_\_

**7-13 years-old SCREENING QUESTIONNAIRE**

<b>Hearing Screening</b>	_____
~ Do you have any concerns about your child's hearing?	( ) yes ( ) no
<b>Vision Screening</b>	_____
~Do you have any concerns about your child's vision?	( ) yes ( ) no
<b>Dental screening</b>	_____
~Does your child get his/her teeth brushed at least twice per day?	( ) yes ( ) no
~Has your child seen a dentist?	( ) yes ( ) no
<b>TB Screening</b>	_____
~Has a family member or contact had tuberculosis disease?	( ) yes ( ) no
~Has a family member had a positive tuberculin skin test (+PPD)?	( ) yes ( ) no
~Was your child born in a high risk country (countries other than the US, Canada, Australia, New Zealand, or Western European countries? Name of country _____	( ) yes ( ) no
~Has your child traveled to a high-risk country for more than 1 week? Name of countries _____	( ) yes ( ) no
<b>Anemia screening</b>	_____
~Does your child have a history of anemia?	( ) yes ( ) no ( ) don't know
~Has your child required iron supplements in the past?	( ) yes ( ) no
~Is your child a strict vegetarian?	( ) yes ( ) no
<b>Domestic Violence Screening</b>	_____
~Do you ever feel unsafe for yourself or your children in your home?	( ) yes ( ) no
~Has your child ever witnessed a frightening or violent experience at home?	( ) yes ( ) no
~Are you concerned that anyone has hurt you or your child physically or sexually?	( ) yes ( ) no
~Have you ever misled your family, friends, or doctors about bruises, cuts, or scratches?	( ) yes ( ) no