

CHILD'S NAME (LAST, FIRST, MI) _____

SPONSOR'S SSN# LAST 4 (last name if different than child) _____

CHILD'S BIRTHDATE _____

15 MONTH SCREENING QUESTIONNAIRE

Hearing Screening	
~Do you have any concerns about your child's hearing?	() yes () no () don't know
Vision Screening	
~Do you have any concerns about your child's vision?	() yes () no () don't know