

Name: _____ Date: _____
 School/Facility: _____ Grade: _____ Room: _____
 Absent: _____ Refused: _____

VISION						HEARING					
Far		Near		Lens		Frequency	500	1000	2000	3000	4000
Right	Left	Right	Left	w/	w/o	Right Ear:					
						Left Ear:					
Comments:						Comments:					

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VISION						HEARING					
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Right	Left	Right	Left	w/	w/o	Right Ear:					
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