Head Start Hearing Screening (0-3 years)
FIRST VISIT

Child's Name: _____ **Family Advocate/HS Site:** _____
(last name, first name)

Date: _____ **Tester:** _____ **Child's Date of Birth**: _____

1. **Is there drainage from either ear?** …….. Yes No
   If no, proceed to step 2. If yes, reschedule screening.

2. **Otoacoustic Emission (OAE) Measures**

   Right ear OAEs.....Pass Refer CNT

   Left ear OAEs..... Pass Refer CNT

   If CNT, state reason here: _____

3. **Follow-up**

   - **Refer for retest in 6-8 weeks** (did not pass or CNT OAE screen).....Yes No
   - **Pass**……..Yes No