Learning on TAP

Vision and hearing screening for school-age children
Follow up referral list

Name:	Class:	Contact phone/email:	Date of birth:
Gender: Male ☐ Female ☐ Other ☐	Referral date:	Reason for referral: Vision and/or eye health ☐	Hearing and/or ear health ☐
Referral location:		Name of referral personnel:	Follow up date:
Notes:			

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Gender: Male ☐ Female ☐ Other ☐	Referral date:	Reason for referral: Vision and/or eye health ☐	Hearing and/or ear health ☐
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