## A colorful flower with a smiley face  AI-generated content may be incorrect.

## Vision and Hearing Developmental Screening Checklist

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_ Date Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed by (Name/Relationship): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all the developmental milestones your child has achieved. If the milestone was achieved outside of the age range, please indicate next to the milestone the age achieved. This tool helps us better understand your child's sensory development and needs, along with any potential hearing or vision concerns.

## 👁️ Vision Development

### 0–3 months

* ☐ Stares at faces
* ☐ Follows moving objects with eyes
* ☐ Begins to look at hands
* ☐ Responds to light and bright colors

### 4–6 months

* ☐ Tracks objects smoothly
* ☐ Reaches for objects with accuracy
* ☐ Recognizes familiar people at a distance
* ☐ Looks from one object to another

### 7–12 months

* ☐ Develops full color vision
* ☐ Watches and mimics hand movements
* ☐ Looks for hidden objects (object permanence)
* ☐ Visually explores environment

### 13–24 months

* ☐ Can spot and point to pictures in books
* ☐ Identifies people or objects by sight
* ☐ Notices small objects or crumbs
* ☐ Demonstrates good hand-eye coordination

### 25–36 months

* ☐ Matches shapes and colors visually
* ☐ Names familiar visual items
* ☐ Imitates drawing lines or shapes
* ☐ Watches and copies complex visual actions
* Has your child had a vision screening or eye exam?

□ Yes □ No

If yes, date and result (pass/ follow up indicated): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you or your pediatrician have any concerns about your child’s vision?

□ Yes □ No

* If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Was your child born prematurely (before 37 weeks gestation)?

□ Yes □ No

If yes, at how many weeks? \_\_\_\_\_\_\_\_\_\_\_

* Did your child spend time in the NICU (Neonatal Intensive Care Unit)?

□ Yes □ No

* **Does your child have a diagnosed vision condition?** (e.g., strabismus, nystagmus, cortical visual impairment)

□ Yes □ No

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you notice any of the following? (Check all that apply)

□ Frequent eye rubbing

□ Squinting or closing one eye

□ Crossed or misaligned eyes

□ Inconsistent eye contact

□ Light sensitivity

□ Holding objects very close to their face

□ Not tracking moving objects

* Does your child seem unaware of people or objects unless they are very close?

□ Yes □ No

## 👂 Hearing Development

### 0–3 months

* ☐ Startles to loud noises
* ☐ Calms to soothing voice
* ☐ Responds to caregiver's voice with alertness or quieting
* ☐ Begins cooing

### 4–6 months

* ☐ Turns head toward sounds
* ☐ Responds to changes in tone of voice
* ☐ Babbles using speech-like sounds (ba, da)
* ☐ Reacts to music

### 7–12 months

* ☐ Responds to name
* ☐ Understands common words ('no,' 'bye-bye')
* ☐ Babbles with more variety of sounds
* ☐ Uses gestures in response to spoken language

### 13–24 months

* ☐ Points to body parts when named
* ☐ Follows simple directions
* ☐ Uses several single words
* ☐ Understands questions (e.g., 'Where’s your shoe?')

### 25–36 months

* ☐ Understands simple stories and songs
* ☐ Uses simple sentences
* ☐ Listens to and enjoys conversations
* ☐ Understands prepositions (in, on, under)
* Did your child pass the newborn hearing screening?

□ Yes □ No □ Don’t know

If no, was a follow-up test done? □ Yes □ No

* Has your child had a formal hearing evaluation since birth?

□ Yes □ No

If yes, date and results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you have any concerns about your child’s hearing?

□ Yes □ No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Does your child have frequent ear infections?

□ Yes □ No

If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last one?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle one: Right ear/ Left ear/ Bilateral

* Has your child ever had ear tubes placed?

□ Yes □ No

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you notice any of the following? (Check all that apply)

□ Does not respond to name being called

□ Seems to hear sometimes but not others

□ Turns up volume on devices too high

□ Does not startle at loud noises

□ Delayed speech or unclear speech

□ Watches others for cues rather than responding to sounds

□ Does not respond to sounds outside their line of sight

* Does your child speak fewer words than expected for their age?

□ Yes □ No

If yes, please estimate how many words they use: \_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_