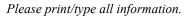
Cook County Department of Public Health Application for Vision and Hearing Services





Date:				<u> </u>	<u>پر</u>	Promoting hea	alth. Preventing disease. Pr
School/Center N	lame:						
Street Address:_							
City:				Zip:_			
Days of week sc	hool/center is open	: Mon T	ue Wed	Thurs	Fri		
Hours school/ce	nter is in session:		_AM to		PM		
Contact Person:				Phone	e:		
	ter was last screene				ıblic H	ealth:	
Is a school nurse	e present/available t	to the school/cer	nter? Yes_		No_		
Number of presc	chool children to be	screened:					
Number of school	ol-age children to b	e screened:					
Screening	Kindergarten	1 st Grade	2 nd G	rade	3 ^r	d Grade	8 th Grade
Vision							
Hearing							
Total							
Number of child documentation is a Number of child Department of C Tuition fee scheen Please list special	rollment: Iren whose family in to be provided at time. The who are subsided the children and Family dule for current schall language needs o	ncome is at or be of application): ized through the Services (Note: ool year attache	elow 200% of a lillinois Dependocumentate d: Yes_led in school	oartment ion is to b	of Hu oe prove No_	man Servic	ees and/or of application):
For CCDPH Us Date application	se Only received						
	tion received						
Date(s) schedule	ed	Tech(s) sc	heduled				
Scheduled by							