

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

Please print/type all information.

Date: _____

School/Center Name: _____

Street Address: _____

City: _____ Zip: _____

Days of week school/center is open: Mon Tue Wed Thurs Fri

Hours school/center is in session: _____ AM to _____ PM

Contact Person: _____ Phone: _____

Date school/center was last screened by Cook County Department of Public Health: _____

Is a school nurse present/available to the school/center? Yes _____ No _____

Number of preschool children to be screened: _____

Number of school-age children to be screened:

Screening	Kindergarten	1 st Grade	2 nd Grade	3 rd Grade	8 th Grade
Vision		-----		-----	
Hearing					-----
Total					

Total School Enrollment: _____

Number of children whose family income is at or below 200% of the Federal Poverty Level (*Note: documentation is to be provided at time of application*): _____

Number of children who are subsidized through the Illinois Department of Human Services and/or Department of Children and Family Services (*Note: documentation is to be provided at time of application*):

Tuition fee schedule for current school year attached: Yes _____ No _____

Please list special language needs of children enrolled in school: _____

For CCDPH Use Only

Date application received _____

Date documentation received _____

Date(s) scheduled _____ Tech(s) scheduled _____

Scheduled by _____