NINOS Early Head Start Hearing Screening

Child's Name: ______________________________ DOB: ____________ Age: __________

Hearing Checklist for Parents / Staff

This list can be used to identify the need for a vision examination and should be shared with the teachers, parents, and child's physician.

Check: Yes / NO

0 to 3 months

- Does your baby get quiet for a moment when you talk to him / her? ☐ **Yes** ☐ **No**
- Does your baby act startled or stop moving for a moment when there are sudden loud noises? ☐ **Yes** ☐ **No**

4 to 6 months

- Does your baby stop turn his/her eyes or head to the head to the sound of your voice if he/she cannot see you? ☐ **Yes** ☐ **No**
- Does your baby smile or top crying when you are someone else he/she knows speaks? ☐ **Yes** ☐ **No**

7 to 9 months

- Does your baby stop and pay attention when you say "no" or call his/her name ☐ **Yes** ☐ **No**
- Does your baby move his/her head around to try to find out where a new sound is coming from? ☐ **Yes** ☐ **No**
- Does your baby make strings of sounds ("ba ba ba, da da da")? ☐ **Yes** ☐ **No**

10 to 15 months

- Does your baby give you toys or other objects (bottle) when you ask, without your having to use a gesture (holding out your hand and pointing)? ☐ **Yes** ☐ **No**
- Does your baby point to familiar objects if you ask ("dog," "light")? ☐ **Yes** ☐ **No**

16 to 24 months

- Does your child use his/her voice most of the time to get what he/she wants or to communicate with you? ☐ **Yes** ☐ **No**
- Can your child go to get familiar objects that are kept in a regular place if you ask him/her ("Get your shoes.")? ☐ **Yes** ☐ **No**

25 to 36 months

- Does your child answer different kind of question ("When..." "Who..." "What...") ☐ **Yes** ☐ **No**
- Does your child notice different sounds (telephone ring, shouting, doorbell)? ☐ **Yes** ☐ **No**

Referral required ☐ Yes ☐ No

Signature of screener: ______________________ **Date of screening:** ______________