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

Cook County DEPT. of Public Health

Promoting health. Preventing disease. *Protecting you.*

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	1st Grade	2nd Grade	3rd Grade	8th 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____