Name____________________ Date__________

7 and 9 Year screening

	Yes	**No**	**Unsure**
1. Do you think that your child has problems with his/her vision?			
2. Do you have concerns that your child has hearing loss?			
3. Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?			
4. Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?			
5. Has a family member or contact had tuberculosis or a positive tuberculin skin test?			
6. Is your child infected with HIV?			
7. Does your child eat a strict vegetarian diet?			
8. Do you have concerns that your child does NOT eat enough iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?			
9. Do you feel you have difficulties providing enough food to feed your family?			
10. Is your child ever around tobacco smoke?			

Development- Is your child doing any of the following:	**Yes**	**No**	**Unsure**
1. Having difficulty with bullies?			

2. Getting along with other children, particularly at school?			
3. Performing academically at grade level?			
4. Getting at least 10 hours of sleep a night?			
5. Getting daily exercise for at least 30 minutes?			