CHILD'S NAME (LAST, FIRST, MI)_____

SPONSOR'S SS# LAST 4 (last name if different than child)_____

CHILD'S BIRTHDATE_____

2 DAY, 2 WEEK, 2 MONTH SCREENING QUESTIONNAIRE

Hearing Screening	[redacted]
~ Do you have any concerns about your child's hearing?	( ) yes ( ) no
Vision Screening	[redacted]
~Do you have any concerns about your child's vision?	( ) yes ( ) no
Domestic Violence Screening	[redacted]
~Do you ever feel unsafe for yourself or your children in your home?	( ) yes ( ) no
~Has your child ever witnessed a frightening or violent experience at home?	( ) yes ( ) no
~Are you concerned that anyone has hurt you or your child physically or sexually?	( ) yes ( ) no
~Have you ever misled your family, friends, or doctors about bruises, cuts, or scratches?	( ) yes ( ) no

Please also complete the separate Post Partum Depression Screen.