



Name: _____ DOB: _____ Student ID#: _____

Campus: _____ Grade: _____ Date: _____

Dear Parent/Guardian: Hearing screenings were recently completed for your child's class. The results of the screening reveal that your child may have difficulty hearing. Please schedule an appointment with your physician as soon as possible for further evaluation. After the physician has evaluated your child and completed this form, please return the top copy to the school nurse.

If your child is already receiving care for this problem, please complete the "Waiver of Referral" at the bottom of this form and return it to the school nurse as soon as possible.

If you have any questions about our screening program or how to obtain further hearing services, please contact me.

Sincerely,

School Nurse

Dear Physician: This child has been referred to you for further evaluation and/or treatment. Below are the hearing screening results and/or observational comments, which indicate the child may have a hearing impairment that could affect his/her educational advancement.

	EAR	1 1000HZ	2 2000HZ	3 4000HZ	Reasons for Referral
___ Second Screen	R				___ Unscreenable ___ Failed Screening ___ Signs & Symptoms
___ Extended Recheck Date: _____	L				

Comments: _____

Screeener: _____

Physician/Audiologist, please complete the following:

Date Examined:

Results:

- ___ conductive hearing loss;
- ___ sensorineural hearing loss;
- ___ mixed hearing loss;
- ___ central auditory problem(s);
- ___ no discernable problem

Recommendation:

- ___ Refer for medical treatment;
- ___ Medical treatment prescribed;
- ___ Hearing aid evaluation and possible fitting;
- ___ Classroom observation for educational implications;
- ___ Placement in aural rehabilitation classroom

Comments: _____

Signature

Title

Printed Name

Return completed referral to school nurse

WAIVER OF REFERRAL

My child, _____, is already under audiologist's care for the problem(s) indicated.

Parent's Signature

Date