

Section I

HEARING SCREENING REQUEST FOR:

Student Name: _____ Birth date: _____ Grade _____

Teacher Name: _____ School: _____

Requested date: _____ Requested by: _____

Date: _____ Parent Permission given: _____

Section II**Initial**

	Date of Screening	1000 Hz	2000 Hz	4000 Hz
Right				
Left				

P=Pass

R=Refer

Follow-Up

	Date of Screening	1000 Hz	2000 Hz	4000 Hz	Tymp
Right					
Left					

A=Normal

B=Abnormal

Section III**Hearing Screening Recommendations:**

Date: _____

_____ Hearing appears to be within the normal range, no follow-up is needed.

_____ Student failed initial screen, a second screen will be completed within 14-21 days.

_____ Students failed initial and follow-up screenings and had abnormal middle ear function. **We suggest the parents take their child to the doctor**, not at school cost, to rule out colds, ear infections, earwax or allergies as possible causes.

_____ Student failed initial and follow-up screenings and had normal middle ear function. **The school will make a referral to the WESD regional Audiologists** to rule out the possibility of a non-medical hearing loss.

_____ Other: _____

Comments: _____

Specialist's Name, Title _____