Burrell School District
Hearing Screening Referral

Name _____ Grade_____

Date _____ Homeroom_____

Dear Parent/Guardian:

Hearing screening service provided as part of the School Health Program has been completed on your child. Results of your child's hearing test are indicated in the table below.

Results of Threshold Hearing Tests

Exam Date	250	500	1000	2000	4000	8000	Pass or Fail
Right Ear							
Left Ear							

The hearing test, as given in the school, is a screening test, and failure of this hearing screening test indicates only that the child should have a more complete ear examination. It is recommended that he/she have a complete diagnostic ear examination by a physician. Please request that the physician complete the other side of this letter. **Return the completed form to your child's school nurse by _____.**

Thank you for your cooperation. If you have any questions, please contact your child's school nurse. Many resources are available if you need assistance in getting an exam for your child.

Sincerely,

_____
Certified School Nurse

_____
Phone number

Burrell School District
Hearing Screening Referral
Physician's Report

Name _____ Date _____

Results of Threshold Hearing Tests

Exam Date	250	500	1000	2000	4000	8000	Pass or Fail
Right Ear							
Left Ear							

Physician's audiogram attached? _____ Yes _____ No

Tentative Diagnosis: _____

Type of hearing loss: _____

Prognosis:
_____
_____
_____
_____

Recommendations:
_____
_____
_____
_____

_____
Physician Signature

(**Return report to School Nurse)**

_____
Physician Phone Number

My child's school nurse may contact the physician named above to clarify any questions concerning my child's hearing.

_____
Parent Signature