# GATEWAYSCHOOL DISTRICT
# Health Services Department

## HEARING SCREENING REPORT

Dear Parent:

_____, did not pass the hearing screening test given at
(Name of Child)

_____ on _____.
(School) (Date)

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 a diagnostic ear examination be completed by a physician.

Please request that the physician complete the lower portion of this form and return it to the school nurse.

Sincerely yours,

_____
(School Nurse's Signature)

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Date: _____

Child's Name: _____

School: _____ Grade: _____

PHYSICIAN'S REPORT – (Physician's Audiogram Attached: Yes ___ No ___ )

Tentative Diagnosis _____

Type of Hearing Loss _____

Prognosis _____

Recommendations _____

_____
(Physician's Signature) (Address