

**PARENT NOTIFICATION REGARDING HEARING
 PART I**

Date _____

Pupil's Name _____

Date of Birth _____

Address _____

Grade _____

To Parent or Guardian:

A recent threshold acuity test indicates that your child shows signs of hearing difficulty. A complete otological examination is recommended to determine the need for professional care and to assist school personnel in making any necessary adjustment of the educational program. This form should be completed by the examining physician and returned to the school nurse-teacher.

 Signature of School-Nurse Teacher

Name of School Administrator _____

School Address _____

To Physician:

This pupil may benefit from hearing services.

The following signs of hearing difficulty have been observed by school personnel:

Report of school's threshold acuity test:

	250	500	1000	2000	4000	6000
Right						

	250	500	1000	2000	4000	6000
Left						

1. Pupil working at grade level? Yes No

2. Previous specialized educational services provided: _____

3. Special educational services now provided:

A. Auditory training Yes No

B. Speech reading Yes No

C. Speech correction Yes No

D. Other special instructional services: _____

FREQUENCY

LEGEND

Right
Red

Left
Blue

10

20

40

100

200

500

1000

3100

1964 - ISO Standard

5000

10000

Right ear unaided

Left ear unaided