SOLVAY UNION FREE SCHOOL DISTRICT
NOTICE REGARDING SCHOOL HEARING SCREENING

Student's Name:_____ DOB:_____ ☐ Male ☐ Female

Address:_____ Grade:_____

To Parent or Guardian: The result of the school hearing screening suggests that your child may have some hearing difficulty. We recommend that your child have a complete ear examination to determine if a problem exists and, if needed, appropriate care. This form should be completed by your health care provider and returned to the school health office.

To Examiner: Your diagnosis and recommendations will be appreciated and will assist in planning the child's school program. A form - Audiometric and Medical Findings - is included for your use.

The following screening results were obtained:

School Observation:

Pure Tone Audiometric Screening: Loss R_____ Loss L_____
Acoustic Immittance Screening: Fail R_____ Fail L_____

Other Comments:_____

Threshold Screening

O = right ear X = left ear

250	500	1000	2000	3000	4000	6000
10 dB						
15 dB						
20 dB						
25 dB						
30 dB						
35 dB						
40 dB						
45 dB						
50 dB						
55 dB						
60 dB						
65 dB						

School Health Professional Signature:_____ Date:_____