Western Wayne School District

School Health Program

Hearing Referral

Name ____ Age_______Sex______
Address____
School______________________________Grade__________Teacher_____________

Dear Parent/Guardian:

Your child _________________________________ did not pass the hearing screening given at Western Wayne High School on ______________________.

Results of Threshold Hearing Tests

	Right Ear						Left Ear						
Date of Exam	250	500	1000	2000	4000	8000	250	500	1000	2000	4000	8000	Pass (P)or Fail (F)

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. This is to include an audiogram.

Please request that the physician complete the other side of this letter. Upon completion, please return this form to your school nurse. Any questions call 1-800-321-9973 and follow the prompts.

Western Wayne High School

School Health Program

Physician Hearing Referral

Child's Name____

Results of Audiogram

Date of Exam	Right Ear 250	500	1000	2000	4000	8000	Left Ear 250	500	1000	2000	4000	8000	Pass (P)or Fail (F)

Tentative Diagnosis: ____

Type of Hearing Loss: ____

Prognosis: ____

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Recommendations: ____

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____
Physician's Name

____
Physician's Signature

____
Address

Please return to the School Nurse

____
Date