THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

HEARING TEST REPORT TO PARENTS AND PHYSICIAN

DATE

NAME OF STUDENT

DATE OF BIRTH

ROOM # GRADE

Dear Parent/Guardian:

We have completed the hearing screening provided as part of the School Health Program. We recommend that your child have a more complete ear examination by a physician.

Reason for referral by the school nurse/practitioner:
Results of Threshold Hearing Test in School:

DATE	RIGHT EAR						LEFT EAR					
	250	500	1000	2000	4000	8000	250	500	1000	2000	4000	8000

Since uncorrected hearing disorders can affect learning, it is important to complete this referral.

Thank you for your cooperation. If you have any questions, or if I can be of assistance to you, please contact me.

CERTIFIED SCHOOL NURSE/PRACTITIONER

SCHOOL

SCHOOL ADDRESS

PHONE NUMBER

IMPORTANT:

Please take this form to your doctor at the time of the examination. When the doctor has completed the information on the back, return it to the school nurse.

PHYSICIAN'S REPORT OF HEARING EVALUATION TO SCHOOL NURSE/PRACTITIONER

NOTE TO THE PHYSICIAN:

IT IS IMPORTANT THAT A COPY OF YOUR AUDIOGRAM BE ATTACHED TO THIS REPORT.

NAME OF STUDENT: ______________________________

DATE OF EVALUATION: ______________________________

DIAGNOSIS: ______________________________

TYPE OF HEARING LOSS: ______________________________

TREATMENT: ______________________________

PROGNOSIS: ______________________________

RECOMMENDATIONS:

SPECIAL SEATING IS ADVISED IN THE CLASSROOM: YES ☐ NO ☐

IF YES DESCRIBE: ______________________________

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DATE OF NEXT APPOINTMENT: ______________________________

OTHER RECOMMENDATIONS: ______________________________

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______________________________ ______________________________

PHYSICIAN'S NAME DATE OF EXAM

______________________________ ______________________________

PHYSICIAN'S SIGNATURE TELEPHONE