**PARENT HEARING REFERRAL NOTICE**

To Parent (s)/Guardian (s) of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade:\_\_\_\_\_\_\_\_\_\_ School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student has failed a hearing screening\* at school and should be examined by a physician. When the examinations is done, please ask your physician to fill out the bottom portion (***Physician Report of Examination***) of this form and return to us as soon as possible.

 **Audiometric Evaluation/Audiogram**

**KEY:**

**Right AC unmasked O**

**Left AC unmasked X**

**Red Box: normal range**

 **Right Ear** **Left Ear**



**\*NOTE: These are hearing screening test and failure indicates that a more complete examination should be done.**

***Physician Report of Examination (to be completed by physician):***

1. Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Recommendation for School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Please return to: TUSD Health Services

 fax: (209)830-3242

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