

**Burrell School District  
Hearing Screening Referral**

Name \_\_\_\_\_

Grade \_\_\_\_\_

Date \_\_\_\_\_

Homeroom \_\_\_\_\_

Dear Parent/Guardian:

Hearing screening service provided as part of the School Health Program has been completed on your child. Results of your child's hearing test are indicated in the table below.

**Results of Threshold Hearing Tests**

Exam Date	250	500	1000	2000	4000	8000	Pass or Fail
Right Ear							
Left Ear							

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. Please request that the physician complete the other side of this letter. **Return the completed form to your child's school nurse by \_\_\_\_\_.**

Thank you for your cooperation. If you have any questions, please contact your child's school nurse. Many resources are available if you need assistance in getting an exam for your child.

Sincerely,

\_\_\_\_\_  
Certified School Nurse

\_\_\_\_\_  
Phone number

**Burrell School District  
Hearing Screening Referral  
Physician's Report**

Name \_\_\_\_\_

Date \_\_\_\_\_

**Results of Threshold Hearing Tests**

Exam Date	250	500	1000	2000	4000	8000	Pass or Fail
Right Ear							
Left Ear							

Physician's audiogram attached?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

Tentative Diagnosis: \_\_\_\_\_

Type of hearing loss: \_\_\_\_\_

Prognosis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Recommendations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(Return report to School Nurse)**

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Physician Phone Number

My child's school nurse may contact the physician named above to clarify any questions concerning my child's hearing.

\_\_\_\_\_  
Parent Signature