FERNDALE AREA SCHOOL DISTRICT

100 Dartmouth Avenue • Johnstown, PA 15905 • [814] 535-1507 • Fax [814] 535-8527

PARENT/GUARDIAN NOTIFICATION

Date _____

Name _____

Address _____

_____

Dear _____,

_____ did not pass the hearing test given at
(Name of Child)

_____ on _____.
(Name of School) *(Date)*

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. You are requested to sign and return this completed form to me.

Sincerely yours,

_____
(School Nurse's Signature)

_____
(School Nurse's Address)

_____

_____
(Telephone)