

Blair Academy Center for Health & Well-Being

2 PARK STREET BLAIRSTOWN, NEW JERSEY 07825 | TEL: 908-362-2010 | FAX: 908-362-7885

Hearing Screening Referral

Name: _____ Date: _____

School: _____ Grade: _____

NJ State Mandate Health Screening. Auditory acuity shall be conducted on all incoming 11th graders. Please have your doctor complete the attached form below and return the form to the school nurse, so that we may update your child's health records. If you have any questions or concerns before you see your doctor, please email me at healthcenter@blair.edu. If your child is under the regular care of an Ear, Nose, and Throat Specialist (ENT), or if you have made an appointment for such care, please let me know and forward any medical documentation such as reports, once received.

Right Ear: 500Hz@_____decibels (dB) 1000Hz@_____dB 2000Hz@_____dB 4000Hz@_____dB

Left Ear: 500Hz@_____decibels (dB) 1000Hz@_____dB 2000Hz@_____dB 4000Hz@_____dB

Other: _____

Sincerely,

Center for Health & Well-Being Team

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PHYSICIAN'S EXAMINATION REPORT

Name: _____ Date of exam: _____

Diagnosis: _____

Type of hearing loss: _____

Prognosis:_____

Recommendations:_____

Physician's Printed Name: _____

Physician's Signature:_____

Office Stamp: _____