HEARING SCREENING PROGRAM
Re-screening Worksheet

Name_____Age_____Grade_____Teacher _____

Parents_____Address _____

Phone_____Health Care Provider _____

Conditions Indicative of Possible Hearing Loss: (teacher observations and health history)

_____Repeated colds
_____Cold today
_____Sore throat today
_____Discharge from ear more than once
_____Discharge from ear today

Frequent earaches:
R_____L_____Both_____

_____Complains of loud, constant ringing in the ears
_____Hearing problems or deafness in family
_____Inattentive
_____Slow responding
_____Repeating grade
_____Says "huh?" or "what" often
_____Speech defect "baby talk"
_____Omits letters
_____Substitutes letters
_____Garbled speech
_____Distorted speech
_____Too soft
_____Too loud
_____Too high pitched
_____Too low pitched

Date of Re-screen _____ decibels		
Frequencies	R	L
1,000		
2,000		
4,000		

Tympanometry			
R Ear	P	F	Type Curve
L Ear	P	F	Type Curve

Referred by nurse to:

_____Family
_____Primary Care Provider
_____ENT Specialist
_____Speech/Language Pathologist
_____Audiologist
_____Other