Screening Tracking Form

SCHOOL	BUILDING	ROOM NUMBER

STUDENT INFORMATION

STUDENT NAME	AGE	GRADE

PARENT NAME	ADDRESS (INCLUDING CITY, STATE & ZIP

Your child has participated in the hearing screening program in our school this year, on _____.

_____Findings indicate a possible problem.

_____It is recommended that your child be evaluated by a physician for medical problems that may be interfering with the ability to hear.

_____It is recommended that your child be evaluated by an audiologist or speech-language pathologist to determine the nature of the problem.

If you have questions, please contact_____/_____
School Nurse Phone

OBSERVATIONS – Check all that apply.

BEHAVIOR		**SYMPTOMS**		**SPEECH**		**HISTORY**	
Often says "huh?" or "what"		Discharge from ears		Speaks too loud or too soft		Seasonal allergies	
Is slow in responding		Complains of earaches		Distorted speech		Frequent upper respiratory infections	
Inattentive		Complains of ringing in ears		Turns one ear to speaker		History of hearing loss in family	
						History of past concerns re: hearing	

RESULT OF SCREENING (Specify type of screening test)

A. SCREENING	DATE	B. RESCREENING	DATE

Results of hearing screening			Results of hearing rescreening		
FREQUENCY	**RIGHT**	**LEFT**	**FREQUENCY**	**RIGHT**	**LEFT**
1,000			1,000		
2,000			2,000		
4,000			4,000		
6,000 (optional)			6,000 (optional)		
			Tympanometry (See Attached graph)		
OBSERVATIONS			**OBSERVATIONS**		

(Continue on back)

This student was screened in the school setting using a pure tone audiometer/and or tympanometry (impedance unit). Screening was done at_____decibels. The student failed the screening and rescreening process. In addition, any other concerns are noted above. It is important that your evaluation results be communicated to the school, as they are essential for our completion of follow-up. We will be happy to assure any recommendations are implemented, and give support to the family regarding this problem and any resulting treatment. You may send the report with the parent, or mail to this address:

SCHOOL NURSE: PLEASE COMPLETE THE FOLLOWING:

SCHOOL NURSE'S NAME	SCHOOL NAME
SCHOOL NURSE'S ADDRESS (INCLUDING CITY, STATE AND ZIP)	PHONE NUMBER (INCLUDE AREA CODE)

RELEASE OF INFORMATION FORM

To the physician:

Please provide the school nurse named above with the results of this evaluation so that the school may be informed and make any necessary adaptations and/or do monitoring of condition.

Signature of Parent/Guardian Date