

**PARENT NOTIFICATION REGARDING HEARING  
 PART I**

Date \_\_\_\_\_

Pupil's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_

**To Parent or Guardian:**

A recent threshold acuity test indicates that your child shows signs of hearing difficulty. A complete otological examination is recommended to determine the need for professional care and to assist school personnel in making any necessary adjustment of the educational program. This form should be completed by the examining physician and returned to the school nurse-teacher.

\_\_\_\_\_  
 Signature of School-Nurse Teacher

Name of School Administrator \_\_\_\_\_ School Address \_\_\_\_\_

**To Physician:**

This pupil may benefit from special educational services.  
 The following signs of hearing difficulty have been observed by school personnel:

Report of school's threshold acuity test:

	250	300	400	500	600	700	800	900	1000
Right									
Left									

- Pupil working at grade level?  Yes  No
- Previous specialized educational services provided: \_\_\_\_\_

- Special educational services now provided:
  - Auditory training  Yes  No
  - Speech reading  Yes  No
  - Speech correction  Yes  No
  - Other special instructional services: \_\_\_\_\_

