Valley School District No. 070

3030 Huffman Road • Valley, WA 99181 • Ph: (509) 937-2791 • Fax: (509) 937-2204 • www.valleysd.org

Referral for Auditory (Hearing) Examination

Report to Parents/Guardians

Dear ____ Date:______________

The results of an auditory (hearing) screening of your child at school indicate a need to have a professional examination by a licensed healthcare provider. Many reasons exist for poor hearing, including wax build-up, temporary health conditions such as a cold, or injury. Your child's auditory screening results are listed below:

Student Name ____ Birthdate _____________ Grade ________

Last *First* *Middle Initial* *m / d / y*

AUDITORY ACCUITY - RIGHT EAR			AUDITORY ACCUITY - LEFT EAR		
DECIBELS	**FREQUENCY**	**NOTES**	**DECIBELS**	**FREQUENCY**	**NOTES**
	1000			**1000**	
	2000			**2000**	
	4000			**4000**	

Please take this form to your child's hearing examination appointment and ask the healthcare provider to provide the results and recommendation(s) in the form section, below. Please return this completed form to the attention of the school nurse in the school office. (*Keep a copy for your records.*)

If you need assistance finding a licensed healthcare provider to do the examination or have any other questions, please contact me at (509) 937-2830 or schoolnurse@valleysd.org. Thank you for your prompt attention to this request and for recognizing the importance of your child's auditory health to his/her academic success.

Sincerely,

Renae Fitzgerald, RN
Valley School District Nurse

HEALTHCARE PROVIDER – REPORT TO SCHOOL NURSE

STUDENT NAME: ____

RESULTS OF AUDITORY (HEARING) EXAMINATION and RECOMMENDATION(S): ______________________________

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PROFESSIONAL RE-EXAMINATION RECOMMENDED BY (DATE): ____

Licensed Healthcare Provider:

Name / Office: ____ Date of Exam: _______________

Signature: ____ Phone No.: _______________

Form #3410F2