*Stars are for office use.

Guthrie Rite Care Language Clinic Screening Program: A hearing screening has been scheduled at your child's school on ***Tuesday, November 2nd.*** . A screening is a "broad" measure of hearing. Tones are presented at the upper limits of the range of normal hearing. A passing score requires that your child respond to all tones presented. If your child fails to respond to any tone, then further screening may be performed, including middle ear screenings. ***Completing and returning this form is extremely important, especially if your child has a history of hearing and/or middle ear problems or if you are concerned with your child's hearing. If your child is on medication for middle ear or upper respiratory problems at the time of the screening, please be sure to note that.***

Results of all children screened will be provided to the school. If your child fails the screening, ***your child's school will send his/her results*** along with our recommendations for further evaluation and sources for services in or near your area. If your child passes the screening, you will not be notified, but you may check with the school if you have any questions.

CHECK HERE IF YOU DON'T WANT THIS CHILD'S HEARING SCREENED _____
It is not necessary to complete the remainder of the form if you checked this box.

If you desire your child's hearing to be screened, please complete, sign and date the following:

Child's Name_____Grade_____Teacher_____

The Guthrie Rite Care Clinic has my permission to screen my child's hearing as described above.

Signature_____ Date_____

Please check all the boxes that apply.

Does this child currently have tubes in his/her ears? No___ Yes___ Left___Right____Both____

Is this child currently being treated for any ear/hearing problems? Yes_____No_____
If yes, date of last Dr.'s examination_____
Type of Problem (Circle all that apply.)
Ear infection Right Left Both
Fluid Right Left Both
Upper Respiratory Illness Allergies
Other _____Explain_____
Recommendations offered by the Dr. _____
Is this child to return to the Dr. after treatment? Yes No If yes, when? _____

When was this child's hearing last evaluated? _____ Recommendations_____

Has this child suffered with chronic middle ear problems in the past? Yes _____No _____

Check here if this child has been diagnosed with a permanent hearing loss _____

Circle which ear(s) Right Left Both Cause _____

Circle the degree of Loss Mild Moderate Severe Profound

Does this child wear hearing aids? Is yes, circle which ear(s): Right Left Both