BAY SHORE PUBLIC SCHOOLS
Bay Shore, New York

School Health Program

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 shows evidence of a hearing loss. Your findings will be helpful in planning special educational services.

The following signs of hearing difficulty have been observed by school personnel:

Report of school's threshold acuity test:

	250	500	1000	2000	4000	6000
Right						
Left						

1. Pupil working at grade level? Yes No

2. Previous specialized educational services provided: _____

3. Special educational services now provided:

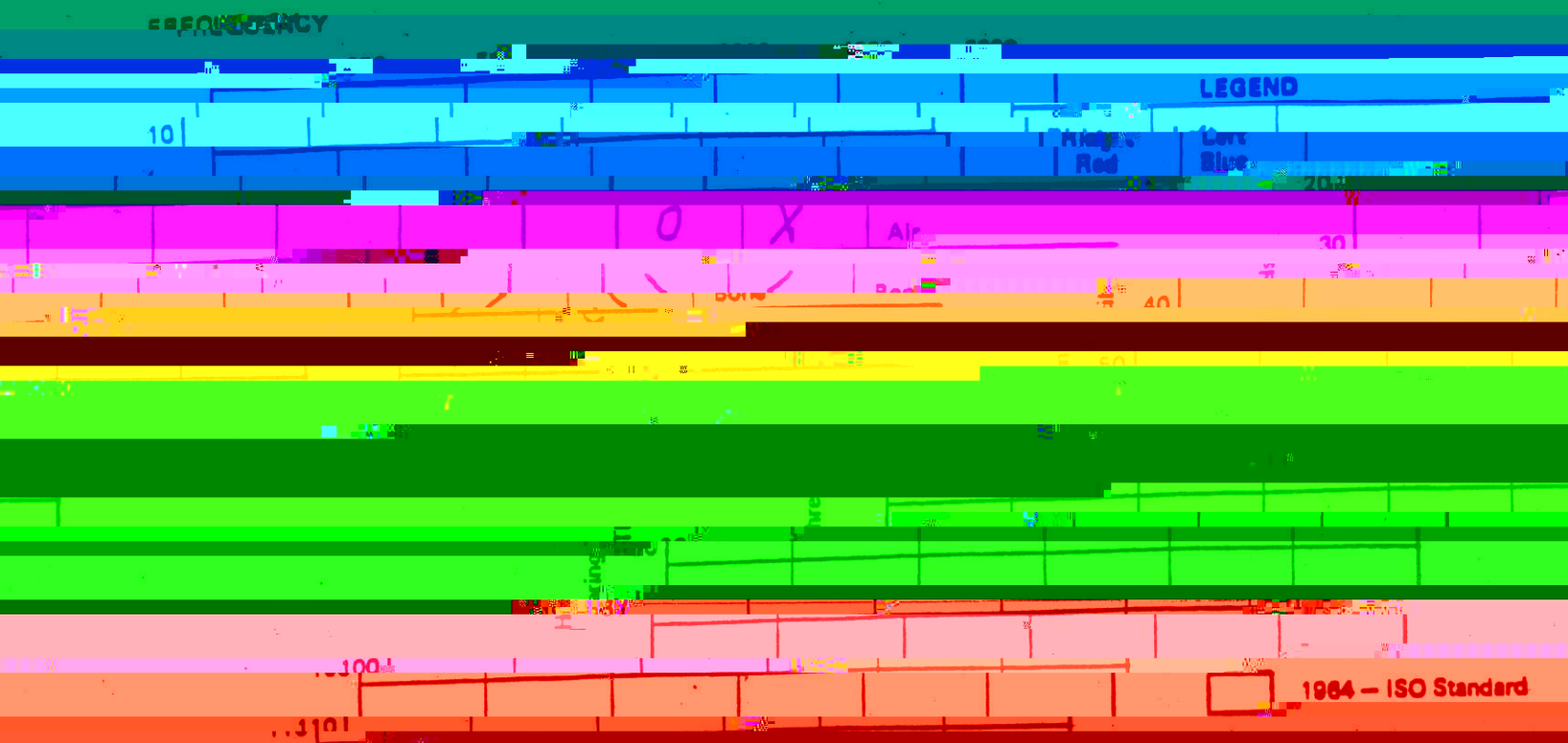
   A. Auditory training Yes No

   B. Speech reading Yes No

   C. Speech correction Yes No

   D. Other special instructional services: _____

PART II — Audiometric and Medical Findings



Administered by:

Diagnosis

Yes ____ No ____

4. Is the child wearing a hearing aid?

5a. Yes ____ No ____

5b. Is an evaluation for hearing aid indicated?

Address of Physician

Date of examination