3192 Turnpike St., Susquehanna, PA 18847 Phone (570) 853-4921 www.scschools.org

Elementary School
Health Office
Ext. 1345 or 1343
Fax: (570) 853-3092

High School
Health Office
Ext. 2347
Fax: (570) 853-3918

Dear Parent or Guardian of ________________________________: Date __________
Students Name

Your child did not pass the hearing test given at school on ____________. The hearing test, as given in the school, is a screening test. Failure of this hearing screening test only indicates that the child should have a more complete ear examination.

It is recommended that he/she have a complete diagnostic ear examination by a physician. This is to include an audiogram.

Please request that the physician complete the other side of this letter. You are also requested to sign and return this completed form to the Health Office.

Sincerely,

Elizabeth Matis, RN
Health Office

Results of School Threshold Hearing Test

Right Ear						*Left Ear*					
250	500	1000	2000	4000	8000 (HZ)	250	500	1000	2000	4000	8000 (HZ)
☐	☐	☐	☐	☐	☐ (dB)	☐	☐	☐	☐	☐	☐ (dB)

Comments: ____

____

Physicians Report

Child's Name: ______________________________________ Age: ________

Address: ______________________________________ Grade: ________

____

School: Susquehanna Community School District

Results of Threshold Hearing Test

Right Ear							*Left Ear*						
250	500	1000	2000	4000	8000	(HZ)	250	500	1000	2000	4000	8000	(HZ)
☐	☐	☐	☐	☐	☐	(dB)	☐	☐	☐	☐	☐	☐	(dB)

Please Circle: PASS FAIL

Physicians Audiogram Attached? ________ Yes ________ No

Tentative Diagnosis ______________________________________

Type of Hearing Loss ______________________________________

Prognosis ______________________________________

____

Recommendations ______________________________________

____

______________________ (Physician Name Printed)

______________________ (Physician Signature) ________ (Date)

______________________ (Physician Address)

____

______________________ (*Parent Signature*) ________ (*Date*)