# PITTSYLVANIA COUNTY SCHOOLS

P.O. Box 232 • 39 Bank Street S.E. • Chatham, Virginia 24531

## HEARING SCREENING

Student's Name ______________________________________________

School ____________________ Grade ____________ Teacher ________________

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TO BE COMPLETED BY CLASSROOM TEACHER:

Dear Parent/Guardian:

Your child has exhibited the following behaviors, which indicated a possible hearing problem:

______ Seems inattentive to auditory tasks.
______ Mouth breathing, draining ears, or earache complaints.
______ Frequent requests to repeat what has just been said.
______ Irrelevant answers to questions.
______ Indistinct speech.
______ Watching the lips of the speaker.
______ Talking either too loudly or too softly.
______ Makes mistakes in following directions and taking dictation.

Comments: ______________________________________________________

________________________________________________________________

With your permission, our school nurse can perform a hearing screening. Please complete the next section of this form and return it to me.

______________ ________________________________

Date Teacher's Signature

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TO BE COMPLETED BY PARENT/GUARDIAN:

________ I give my permission for my child to be given a hearing screening by the school nurse.

OR

________ I do not give my permission for my child to be given a hearing screening by the school nurse.

Comments: ______________________________________________________

________________________________________________________________

______________ ________________________________

Date Parent's Signature

TELEPHONE NUMBERS: (434) 432-2761 • (434) 793-1624 (Danville) • (434) 656-6248 (Gretna) • FAX (434) 432-9560

TO BE COMPLETED BY THE SCHOOL NURSE:

Your child's hearing was checked at school today and the following results obtained:

_______ Hearing is found to be normal.

_______ He/she needs to see a doctor because:

- ______ He/she was unable to pass the hearing screening.
- ______ The ear canal is impacted with wax.
- ______ Other: ______________________________________________

  ______________________________________________

  ______________________________________________

Comments: ______________________________________________

______________________________________________

If you have questions or are in need of assistance, feel free to contact me at the telephone numbers below or leave a message for me at your child's school

______________ ______________________________

Date School Nurse's Signature

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TO BE COMPLETED BY PROFESSIONAL EXAMINER:
PHYSICIAN'S FINDINGS AND RECOMMENDATIONS:

______________________________

Student's Name

_______ No significant findings at this time.

_______ Treatment necessary and prescribed.

_______ Referred to consultant for further evaluation.

Comments: ______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________ ______________________________

Date Physician (Please Print)

______________________________

Physician's Signature

RETURN COMPLETED FORMS TO SCHOOL NURSE FOR DOCUMENTATION AND FILING