

PARENT/GUARDIAN NOTIFICATION

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Dear \_\_\_\_\_:

\_\_\_\_\_ did not pass the hearing test given at  
(Name of Student)

\_\_\_\_\_ on \_\_\_\_\_.  
(Name of School) (Date)

Results of Threshold Hearing Tests

DATE OF EXAM	RIGHT EAR						LEFT EAR						PASS (P) OR FAIL (F)	
	250	500	1000	2000	4000	8000	250	500	1000	2000	4000	8000		

The hearing test, as given in the school, is a screening test, and failure of this hearing screening test indicates only that the student 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 provider complete the other side of this letter. You are requested to sign and return this completed form to me.

Sincerely yours,

\_\_\_\_\_  
(School Nurse's Signature)

\_\_\_\_\_  
(School Nurse's Address)

\_\_\_\_\_  
(Telephone)