

Ohio Department of Health Hearing Report

School Screening Information

Child's Name	Date
School	Grade
Reason for referral (test failed or type of symptom)	

Physician/Audiologist

Was treatment for the hearing problem necessary for this child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did you initiate this treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wish to see this child again? <input type="checkbox"/> Yes <input type="checkbox"/> No When	
Summary of hearing problem and diagnosis, if indicated <hr/> <hr/>	
Recommendations (speech/language and hearing therapy, avoid swimming, etc. if indicated) <hr/>	
Additional comments for teacher (preferential seating, etc.) <hr/> <hr/>	

Please return form to

	Signed by specialist:
	Address
	Date