

**ISSAQUAH SCHOOL DISTRICT
SPECIAL SERVICES
AUDITORY SCREENING REFERRAL
(WAC 248-144-010)**

Dear Parent:

Your child, _____, received a hearing acuity screening on _____.

At this time, it appears that **his/her hearing is not within the normal limits. The results below were obtained at the specified frequencies:**

Right ear:	1000Hz _____	2000Hz _____	4000Hz _____
Left ear:	1000Hz _____	2000Hz _____	4000Hz _____

[] The results of the hearing screening indicate that your child should be seen by a physician for further evaluation. *The Physician's Report to School* on the reverse side of this form is to be completed by the physician. In order for the physician to release this information to us, we will need your signature on the reverse side of this page. This information is necessary to provide the best educational programming for your child.

[] A review of your child's hearing record indicates that your child has a known hearing loss.

The results of the hearing screening indicate that at this time:

- [] There is no change from last year's screening.
- [] A medical and/or audiological follow-up is needed.
- [] Your child should have preferential seating as a classroom recommendation.

If you have any questions, please phone me at: _____

Sincerely,

Speech/Language Pathologist

In order to provide a safe and healthy environment for your child this information will be accessible to the following people: Principal, nurse, your child's teachers, secretaries, and personnel responsible for health room coverage.

(over)

Issaquah School District #411

Physician's Report to School

Student _____ Birthdate _____
Last First Middle

From Parent/Guardian:

For the purpose of gathering data relevant to educational programming, I authorize the exchange of information regarding my son/daughter between the Issaquah School District, employee(s) and physician listed below.

	Employee(s)		Parent/Guardian
Name/Title	_____	Signed	_____
Name/Title	_____	Relationship to student	_____
Name/Title	_____	Phone #	_____ Date _____

In compliance with the Family Educational Rights and Privacy Act, all information received by the Issaquah School District concerning this student will be available for inspection by the parent/legal guardian. Such information will be forwarded to other persons and organizations only in accordance with procedures specified in the Family Educational Rights and Privacy Act.

To Physician:

We have asked _____ to consult you because of the above named student's failure to pass two school hearing screenings. **If you retest the hearing, please attach the audiogram to this report so that we may include it on the student's health card. Please complete the information requested below.**

1. Diagnosis _____
2. Treatment recommendations _____
3. Significance of auditory handicap in regard to the learning process _____
4. Need for further audiometric evaluation of follow up (please specify) _____
5. General summary _____

Physician's signature **Address** **Date**

Please print physician's name

Please address information sent to Issaquah School District regarding this student to: _____
School Address: