

North Schuylkill School District
PHYSICIAN/HEARING SPECIALIST REPORT

Child's Name: _____ Age: _____

School: _____ Grade: _____

The hearing test, given at school is a screening test, and failure of this hearing test indicates that the child should have a more complete ear exam. It is recommended that he/she have a complete diagnostic ear exam by a physician. Please ask the doctor to complete the bottom portion of this form and return to the school nurse.

Results of Threshold Hearing Tests

RIGHT EAR

LEFT EAR

Date of Exam	250	500	1000	2000	4000	8000		250	500	1000	2000	4000	8000	Pass (P) or Fail (F)

Physician Report

Provider Audiogram Attached? _____ Yes _____ No

Tentative Diagnosis:

Type of Hearing Loss:

Prognosis:

Recommendations:

 (Provider's Signature) (Date)

 (Address)

 (Telephone)

North Schuylkill Elementary School
38 Line St.
Ashland, PA 17921
570-874-3661 x-3015 ** fax 570-874-2857

Name _____ Grade _____ Date _____

Dear Parent/Guardian:

Vision screening service provided as part of the School Health Program has been completed on your child. Results of your child's vision test indicate the need for an eye examination by an Eye Care Specialist. Please request the examiner complete the bottom portion of this letter. Return the completed form to your child's school nurse as soon as possible.

Since uncorrected vision disorders can affect learning potential, it is important to have your child's Eye Care Specialist complete the form below and return it to the school.

Thank you for your cooperation. If you have any questions, please contact your child's school nurse.

Brandy Sullivan, RN, BSN
Certified School Nurse

REPORT OF EYE EXAM

Name _____

Visual Acuity:	FAR	NEAR
	<u>Right / Left</u>	<u>Right / Left</u>
	With glasses: _____	_____
	Without glasses: _____	_____

Diagnosis or explanation of eye condition:

Plan of Treatment:

Glasses Prescribed	Yes ___ No ___	Prescription Change	Yes ___ No ___
Constant Wear	Yes ___ No ___	Near Work Only	Yes ___ No ___
Distance Work Only	Yes ___ No ___	Contacts Prescribed	Yes ___ No ___
Best Correction	Yes ___ No ___		

Recommendation for school:

Signature of Eye Care Specialist: _____

Date: _____