POMONA UNIFIED SCHOOL DISTRICT
Health Services & Programs
Referral for Hearing Evaluation

TAKE THIS FORM TO YOUR DOCTOR

Student: _____ Grade:_____

School: _____

Dear Parent/Guardian:

As a result of recent school screening tests, your child should have a complete hearing evaluation. **It is recommended that an ear specialist evaluate your child. Please contact the school nurse if you need assistance with resources for care or if you need financial assistance.**

Date: _____ School Nurse: _____ 397_____

This referral is based on a hearing-screening test. See the attached audiogram. Thank you for returning this form to facilitate the educational process.

IF MAILED:
School _____
Address _____
_____
Phone _____
Attn: School Nurse

EXAMINER'S REPORT TO SCHOOL

This student was examined on _____.

Findings indicate _____

Preferential seating recommended: Yes _____ No _____

Student is scheduled for further evaluation on _____

Recommendations/comments: _____

Parent signature for release of information: _____

PLEASE PRINT

Doctor's Name _____ Signature: _____

Address: _____ Date: _____

Phone: _____

Please return to school nurse when completed by doctor.