Fresno County
Superintendent of Schools

Health Services
Alma McKenry, Senior Director

Hearing Referral

Name: _____ Date: _____

School: _____ Room/Teacher: _____ Grade: _____

Dear Parent:

Your son / daughter _____ has had difficulty passing the school hearing test. The results are below.

Please consult your doctor and request a report on the lower portion of this form. If you wish to talk to the school nurse, please contact the school at: _____ on: _____.

If this time is not convenient, please call or write to the school nurse for an appointment.

Date		500	1000	2000	3000	4000	6000
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_____
School Nurse

Physician's Report

This report is to be returned to the school nurse by the parent or the pupil. Your recommendations will assist us in adjusting the child's school program.

Findings and diagnosis:

Management:

Referred to other physician: _____

Follow-up as needed: _____

_____ _____
Signature of Physician Date

_____ _____
Physician Address Telephone