Hearing Screening Form

Child's Name:_____

Grade:_____

Screening Date:_____

Room Noise: ◯ Good ◯ Fair ◯ Poor

Hearing Screening Results (Pure-Tones)

Frequency (Hz)	**1000 Hz**	**2000 HZ**	**4000 HZ**
Right Ear at **20 Decibels**	Pass_____ (20 dB) Refer_____	Pass_____ (20 dB) Refer_____	Pass_____ (20 dB) Refer_____
Left Ear at **20 Decibels**	Pass_____ (20 dB) Refer_____	Pass_____ (20 dB) Refer_____	Pass_____ (20 dB) Refer_____

_____Your child passed today's hearing screening.

_____Your child did not pass today's hearing screening. We will retest in few weeks.

_____ Your child did not pass today's hearing screening. Please follow-up with a primary care provider or audiologist.

Comments:

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