



Name	Date of Birth / /	Screening Program
Parent's Name	Screening Location	
Street Address	Referred By	
City	County	

## EAR EXAMINATION

<b>AUDITORY CANAL</b> R L <input type="checkbox"/> <input type="checkbox"/> NO FINDINGS <input type="checkbox"/> <input type="checkbox"/> FINDINGS →		<b>OCCLUDED</b> R L <input type="checkbox"/> <input type="checkbox"/> PARTIALLY <input type="checkbox"/> <input type="checkbox"/> COMPLETELY		<b>OCCLUDED BY</b> R L <input type="checkbox"/> <input type="checkbox"/> CERUMEN <input type="checkbox"/> <input type="checkbox"/> FOREIGN BODY		R L <input type="checkbox"/> <input type="checkbox"/> INFLAMMATION <input type="checkbox"/> <input type="checkbox"/> OTHER (DESCRIBE)	
<b>DRUM</b> R L <input type="checkbox"/> <input type="checkbox"/> NO FINDINGS <input type="checkbox"/> <input type="checkbox"/> FINDINGS → <input type="checkbox"/> <input type="checkbox"/> NOT VISIBLE		R L <input type="checkbox"/> <input type="checkbox"/> DULL <input type="checkbox"/> <input type="checkbox"/> BULGING <input type="checkbox"/> <input type="checkbox"/> RETRACTED <input type="checkbox"/> <input type="checkbox"/> PERFORATED		R L <input type="checkbox"/> <input type="checkbox"/> SCARS <input type="checkbox"/> <input type="checkbox"/> OPAQUE <input type="checkbox"/> <input type="checkbox"/> RED <input type="checkbox"/> <input type="checkbox"/> OTHER (DESCRIBE)			

## NOSE AND THROAT EXAMINATION

<b>TONSILS</b> <input type="checkbox"/> REMOVED COMPLETELY <input type="checkbox"/> TONSILS PRESENT (NORMAL) <input type="checkbox"/> TONSILS PRESENT (ENLARGED)		<b>ORAL PHARYNX</b> <input type="checkbox"/> NO FINDINGS <input type="checkbox"/> CLEFT PALATE <input type="checkbox"/> REPAIRED <input type="checkbox"/> UNREPAIRED		<input type="checkbox"/> POST NASAL DISCHARGE <input type="checkbox"/> MOUTH BREATHING <input type="checkbox"/> OTHER (DESCRIBE)	
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## DIAGNOSIS

<input type="checkbox"/> CANAL OBSTRUCTIONS <input type="checkbox"/> SEROUS OTITIS MEDIA <input type="checkbox"/> DRUM PERFORATION <input type="checkbox"/> ALLERGIES <input type="checkbox"/> OTHER (DESCRIBE) _____ _____	<input type="checkbox"/> CONDUCTIVE HEARING LOSS <input type="checkbox"/> SENSORI-NEURAL HEARING LOSS <input type="checkbox"/> CONFIRMED BY BONE CONDUCTION AUDIOMETRY <input type="checkbox"/> CONFIRMED BY TUNING FORK <input type="checkbox"/> MIXED HEARING LOSS <input type="checkbox"/> OTHER (DESCRIBE) _____ _____
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COMMENTS

## TREATMENT

I SUGGEST A REPEAT AUDIOGRAM IN \_\_\_\_\_ WEEKS.

<b>RELEASE OF INFORMATION</b> CONSENT OF PARENT OR GUARDIAN I agree to release the above information on my child or ward to appropriate health and/or school authorities.  _____ SIGNATURE OF PARENT OR GUARDIAN	Date of Examination / /
	Stamp or Print Physician's Name _____ Address _____ _____

PLEASE RETURN THIS FORM TO \_\_\_\_\_

NAME OF SCHOOL