



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

EAR EXAMINATION

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

NOSE AND THROAT EXAMINATION

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

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

TREATMENT

I SUGGEST A REPEAT AUDIOGRAM IN _____ WEEKS.

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

PLEASE RETURN THIS FORM TO _____

NAME OF SCHOOL