HEARING REFERRAL FOLLOW-UP

Student Health Services
Telephone: (806) 219-0466
FAX: (806) 766-6680

Name of Student: _____ Date: _____

Teacher: _____ Grade: _____

A referral letter was sent home with your child previously this school year to inform you that your child needs to be evaluated by a physician due to hearing screening results obtained during a health screening at our campus. In an effort to follow-up on that referral, I would appreciate it if you would please complete the form below and return it to me as soon as possible. If you have any questions or if I may be of assistance in any way, please contact me at .

Thank you for your assistance.

Sincerely,

_____

School Nurse

219-

PLEASE RETURN THIS PORTION OF THE FORM TO THE SCHOOL NURSE AS SOON AS POSSIBLE

Name of Student: _____ Date: _____

Teacher: _____ Grade: _____

_____ My child has been examined by a physician and the following treatment was received.

_____

_____

_____ My child has been examined by a physician and no problems were identified.

_____ My child has NOT been examined by a physician. I need assistance with this process. Please contact me at (your phone number).

_____

Parent's Signature