

Educational Screening Form for Students with Suspected or Confirmed Hearing Loss

Student Name _____ Birthdate _____ Gender Male / Female

Primary Language _____ Grade _____ School _____ School Phone(_____)_____

Teacher _____ Current related services _____

Current special education program _____ Last Audiological Evaluation Date: _____ (must be within 1 year)

Please have the teacher answer the following questions:
Describe any concerns about this student's ability to hear in the classroom:

Do you feel that this child's ability to hear is impacting academic performance? If so, how and how significantly?

Please describe where the student is seated in the classroom:

Please Answer The Following:

| | | | |
|---|---|---------|-----|
| Does this student use an amplification device? | | YES | NO |
| List type of amplification devices. (hearing aid, cochlear implant, etc.) | _____ | | |
| If so, is the amplification device worn consistently? | | YES | NO |
| Does this student have difficulty: | listening in the presence of noise? | YES | NO |
| | following verbal directions? | YES | NO |
| | discriminating similar-sounding words? | YES | NO |
| | starting a task without looking at peers? | YES | NO |
| | responding to spoken language? | YES | NO |
| Is this child easily frustrated? | | YES | NO |
| Is this student's attention span shorter than his/her peers? | | YES | NO |
| Is this student more distractible than others in the classroom? | | YES | NO |
| This student's overall academic skills? | HIGH | AVERAGE | LOW |
| Do you feel that this student's achievement reflects his/her potential? | _____ | | |

For modified/assisted programming students, please describe performance, functioning, and school environment:

Additional comments and information _____

Signed: _____ Title: _____ Date: _____