FERNDALE AREA SCHOOL DISTRICT

100 Dartmouth Avenue • Johnstown, PA 15905 • [814] 535-1507 • Fax [814] 535-8527

PARENT/GUARDIAN NOTIFICATION

										Date					
Name															
Addres	ss														
Dear								,							
(Name of Child)									_ did not pass the hearing test given at						
	(Name of School)									on (Date)					
				Res	ults of	Thres	shold	Hear	ring To	ests					
	RIGHT EAR								LEFT EAR						
DATE OF EXAM	250	500	1000	2000	4000	8000	250	500	1000	2000	4000	8000	PASS(P) OR FAIL (F)		
The hearing test, as given in the school, is a screening test and failure of this hearing screening test indicates only that the child should have a more complete ear examination. It is recommended that he/she have a complete diagnostic ear examination by a physician. This is to include an audiogram.															
physic	ian.	This i	s to inc	clude a	ın audı	ogram	•								
Please to sign	-		-	-		-		her si	de of t	his let	ter. Yo	ou are	requested		
	Sincerely yours,														
									(School Nurse's Signature)						
									(School Nurse's Address)						
										(Tele	phone)				

It is the policy of the Ferndale Area School District to ensure an equal opportunity in employment and/or program services without any consideration of an individual's race, color, national origin, sex, gender identity or expression, age, religion, disability, veteran status, genetic information, and/or any other characteristic protected by federal, state or local law. An Equal Opportunity Employer.