

SEDGWICK COUNTY AREA EDUCATIONAL SERVICES INTERLOCAL COOPERATIVE

AUDIOLOGY INFORMATION FORM

(Complete ONLY if an audiology evaluation is needed, but a comprehensive evaluation is **not** requested)

STUDENT'S NAME: _____ SCHOOL: _____

TEACHER: _____ GRADE: _____ BIRTHDATE: _____

PARENT'S NAME: _____ HOME PHONE: _____

MOTHER'S WORK PHONE: _____ FATHER'S WORK PHONE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PLEASE CIRCLE **YES** OR **NO** IN RESPONSE TO THE FOLLOWING:

- | | | | |
|-----|--|-----|----|
| 1. | To your knowledge has this child had chronic middle ear problems? | Yes | No |
| 2. | Does child's ability to respond to speech or noise change from day to day? | Yes | No |
| 3. | Does child seem to hear but not understand? | Yes | No |
| 4. | Does child use a voice that is louder or softer than normal? | Yes | No |
| 5. | Does child have more difficulty with oral directions than with written directions? | Yes | No |
| 6. | Does child have preferential seating? | Yes | No |
| 7. | Is child easily distracted when background noise is present? | Yes | No |
| 9. | Does the child often give wrong answers to questions or fail to carry out simple directions? | Yes | No |
| 10. | Does child need statements and directions repeated more often than the average student? | Yes | No |

Other comments you feel might be of help:

Thanks for your concern. The results of the evaluation will be shared with you.
This form should be used when audiology is not part of a comprehensive evaluation.
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