TUCSON UNIFIED
SCHOOL DISTRICT

HEARING RISK INDICATORS

Child's Name:_____ DOB:_____

Form filled out by:_____ Date: _____

		YES	NO	
1.	Do you have any concerns regarding your child's hearing, speech, language, or development?			If YES, please explain:
2.	Did your child pass the newborn hearing screening?			If NO, please explain:
3.	Is there a family history of hearing loss?			If YES, please explain:
4.	Was your child in the neonatal intensive care unit for more than 5 days?			If YES, please explain:
5.	Were there any in utero infections (cytomegalovirus, herpes, rubella, syphilis, toxoplasmosis)?			If YES, please explain:
6.	Are there any craniofacial anomalies, including those that involve the ear, ear canal, ear tags, ear pits?			If YES, please explain:
7.	Has your child been diagnosed with a syndrome?			If YES, please explain:
8.	Has your child had ear infections?			If YES, how many?
9.	Has your child had ear surgery (P.E. Tubes)?			If YES, please explain:
10	Has your child had any head trauma, especially a skull fracture that required hospitalization?			If YES, please explain:
11	Has your child received chemotherapy?			If YES, please explain: