Medical Clearance Form

*Child:*_____*DOB*:_____

We are evaluating the above student for eligibility as a special education student and/or for medical clearance of personal amplification. Please complete this form and return it as soon as possible.

DIAGNOSIS/IMPRESSIONS

Type of hearing Loss			**Degree of Hearing Loss**		
Right	**Left**	*(Please check one)*	**Right**	**Left**	*(Please check one)*
		Within Normal Limits			Mild
		Conductive			Moderate
		Sensorineural			Severe
		Mixed			Profound
		Auditory Neuropathy			Other *(please specify)*:

☐ **No Medical Contraindications for Amplification** *(Please check if applies)*
☐ **Hearing loss is considered to be lifelong and permanent** *(Please check if applies)*

Comments: _____

_____

EXAMINING ENT PHYSICIAN

Last Name:	*First Name:*	
Address:		
City:	*State:*	*Zip Code:*

_____ _____

Otologist (ENT) Signature Required *Date*