Hearing Health Screening Permission Form

Child Health Worker: Bailea Fatnowna
Phone: 4633 9500

Please fill out all of the information to enable your child to be screened

Child's Information

Full Name:			
D.O.B:		Age:	
School:		Gender:	☐ Male ☐ Female
Is your child a current Carbal Medical Services client?		☐ Yes	☐ No
Usual Doctor Name:			
Medical Centre Name:			
Ethnicity:	Aboriginal / Torres Strait Islander / Both / Non Indigenous		

Parent/Guardian Contact Information

Parent Name:		Relationship to child:	
Home Address:			
Phone Number:			

To assist with the screening, please answer the following:

Does your child snore?	Yes	No	Not Sure
Does your child use cotton buds in his/her ears?	Yes	No	Not Sure
Does your child suffer from nasal congestion?	Yes	No	Not Sure
Does your child have or has ever had grommets?	Yes	No	Not Sure
Does your child suffer from Vertigo? (dizziness)	Yes	No	Not Sure
Does your child suffer from ear infections/sore ears?	Yes	No	Not Sure
Does your child have any allergies?	Yes	No	Not Sure
If yes, what allergies & reactions do they have?			

Concerns:

Do you have any concerns about your child's hearing?

_____

Permission:

I the Parent (listed above) give permission for my child (listed above) to be provided assessment & follow up services for Hearing Health by the Carbal Medical Services Aboriginal Child Health Worker for the entire duration of 2018. To provide a comprehensive service, I also give permission for information to be shared with other health professionals where required.

Signature: _____ Date: _____