



District Superintendent  
Randall W. Heller

# Winton School District

7000 N Center Street  
P.O. Box 8  
Winton, CA 95388-0008  
(209) 357-6175 Fax: (209) 357-1994  
EEO Affirmative Action Employer

## Board of Trustees

**Corine Dusin, President**  
**Marie Gonzales, Clerk**  
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Dear Parent,

As required by section 49452 of the California Education Code and pursuant to section 2951, California Administrative Code. Title 17 (Public Hearing). \_\_\_\_\_ was given hearing tests at school. The test results indicated that your child may have a hearing defect. Therefore, it is suggested that you arrange to have your child examined by a doctor. Please give the enclosed letter and hearing test reports to your child's doctor. Kindly complete the lower portion of this letter and return it to the school.

Sincerely,

\_\_\_\_\_  
School Nurse

<i>Kimberly Sherman</i> Winfield Principal (209) 357-6891	<i>Ka Vang</i> Frank Sparkes Principa (209) 357-6180	<i>Kim Cuthriell</i> Sybil Crookham Principal (209) 357-6182	<i>Kristie Warner</i> Winton Middle Principal (209) 357-6189
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Enclosures: (Letter to Doctor and audiograms and/or tympanogram)

Child's Name \_\_\_\_\_ School \_\_\_\_\_

Check one:

- The report will be given to our child's doctor.
- Our child is receiving medical treatment for his hearing or ear problem.
- I would like to discuss this matter with the school nurse.

Date: \_\_\_\_\_

\_\_\_\_\_  
(Parent's Name)

\_\_\_\_\_  
(Parent's Phone Number)

# AUDIOLOGICAL REPORT



**Winton School District**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ GRADE: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ TEACHER: \_\_\_\_\_

Frequencies

500      1000      2000      4000      500      1000      2000      4000

Right							
Left							

Date: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Your signature authorizes your child's doctor to exchange medical information with the school nurse. Thankyou for your cooperation.

Signature of Parent/Guardian	Date
Signature of School Nurse	Date
Name of School	Phone/Fax
Address of School	

Dear Doctor,  
 The above named student did not pass the school hearing test. A report of your findings and recommendations would be most helpful. Thank you.

REPORT OF PHYSICIAN TO THE SCHOOL

Diagnosis \_\_\_\_\_  
 Medical Treatment Prescribed \_\_\_\_\_

Follow-up \_\_\_\_\_  
 Recommendations and comments \_\_\_\_\_

Signature of Physician \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ Fax \_\_\_\_\_  
 City \_\_\_\_\_