Sunshine Cottage

A Listening and Spoken Language School for Deaf Children

OTOLOGIC EXAMINATION AND CLEARANCE REPORT

Child's Name	Date of Birth	Date of Examination

Diagnosis Code(s): _____ Etiology: _____

Parent/Guardian Name(s): _____

Please check the statement that is correct for this person:

Right	Left	Both	
☐	☐	☐	The person listed above has been examined and can wear the necessary hearing technology needed to access speech and language.
☐	☐	☐	The person above has a medical condition that prevents the current use of hearing technology.
☐	☐	☐	The person above can wear hearing technology following treatment of the medical condition listed below:

Examination and Test Results (Otoscopic, CT Scan, MRI, Genetic testing, etc.):_____

_____

_____

RECOMMENDATIONS:

Genetic testing: Yes _____ No _____ Scheduled Date:_____

Ophthalmologic evaluation: Yes _____ No _____ Scheduled Date:_____

MRI/ CT Scan: Yes _____ No _____ Scheduled Date: _____

Other: _____

_____

Signature of Otologist/Otolaryngologist

_____

(Please Print) Physician's Name

_____

Address

Date of Return Appointment: _____ _____

Telephone Number