

Government of Western Australia Child and Adolescent Health Service WA Country Health Service

COMMUNITY HEALTH

CONSENT FOR EAR HEALTH SCHOOL SCREENING

| Surname; |
|-------------|
| Given name: |
| Gender: |
| School: |
| Address: |

Dear Parent/Guardian

Healthy ears and good hearing are very important for children to help their talking, listening, reading and learning.

With your consent, a Community Health Nurse or Aboriginal Health Worker will:

- 1. Look at the outside of the ear and look inside the ear canal with an otoscope (ear screening torch). This may include taking a picture of your child's eardrum.
- 2. Check hearing by placing headphones over your child's ears and playing different sounds.
- 3. Use a small device that measures how the ear drum moves and checks how the middle ear is working.

If your child is uncomfortable or in pain, we will not continue with the tests.

(Full name of parent/legal quardian)

We will send the results of the ear health check home with your child. The Community Health Nurse may also ring you.

Please fill in this form and return to the school as soon as possible. If you want to talk to the Community Health Nurse, please contact through your child's school.

| for | (Child's full name) | / / (Child's date of birth) | | | | |
|-------|--|--|--|--|--|--|
| to I | nave his/her ears examined by Health staff and allow staff to obtail d relevant information (written or verbal) with other agencies and | in, release and exchange reports individuals in relation to my child. | | | | |
| Re | lationship to child: Phon | e: | | | | |
| Ple | ase tick ONE box below: | | | | | |
| | I ALLOW my child to participate in the ear health screening | | | | | |
| | I DO NOT allow my child to participate in the ear health so | reening | | | | |
| Ple | ase tick the box(es) below (you can tick more than one) | , a 1 | | | | |
| | I have concerns about my child's hearing / ear health | | | | | |
| | My child has a history of ear health problems (such as ear | discharge or pain) | | | | |
| | My child is already receiving ear health services | | | | | |
| LEASE | SIGN HERE Parent/Legal guardian signature: | 200 | | | | |

Please see over page

give permission

EAR HEALTH QUESTIONNAIRE

Recent illness can affect ear health screening. Please complete this questionnaire. Please tick (1/2) the relevant box Has your child: 1. been sick in the last 2 weeks had a cold in the last 2 weeks Has your child recently had any discharge (runny ear) from: 2. ☐ LEFT ear RIGHT ear . BOTH ears Has your child been complaining of pain in: 3. ☐ LEFT ear ☐ RIGHT ear ☐ BOTH ears If you ticked any of the above, has your child been taken to a Doctor? ☐ No ☐ Yes Outcome from Doctor's visit: ear syringe antibiotics further follow up with Doctor referral Has your child been seen by/or have an appointment with an Audiologist? 4. Name _____ Last appointment ______(day/month/year) Has your child been seen by an Ear Nose and Throat (ENT) specialist? 5. Name ___ (day/month/year) Last appointment _____ What did the ENT specialist do? no further action grommets inserted _____(month/year) (month/year) tonsils removed _____ tonsils and adenoids removed _____(month/year)

Thank you for answering this questionnaire.

Other surgery on _____(month/year)

This document can be made available in alternative formats on request for a person with a disability.

Please contact childcommunity@health.wa.gov.au.



