MATER DEI
PRIMARY SCHOOL

53 Curzon Street
East Toowoomba Q 4350
Phone: 07 4637 6100
Email: materdei@twb.catholic.edu.au

Student Name: ____ DOB: ____________________

Parent Name(s) and Contact Details:

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I / We will be attending the hearing test appointment with my child ☐

Has your child ever experienced the following: (*if yes, please describe the occurrences, timeframe, medical treatments & outcomes*)

☐ Ear Infections ____

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Age when ear infection first recognised? ____

☐ Tonsillitis ____

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☐ Grommets ____

How many times and at what age(s) were they inserted? ______________________________

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☐ Glue Ear ____

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Is there a family history of hearing health? (including siblings, parents, etc – are there others who heave ear infections or hearing loss?)

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What is your perception of your child's listening skills at home? *(Do you need to repeat the information often, speak loudly, gain your child's attention prior to speaking with them?)*

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Describe your child's speech and language development? *(Were they late to start speaking, are some sounds they make 'slushy' or incorrect e.g. tree – free, school – sool, swimming – wimming?)*

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How is your child when they get home from school? *(Tired, scatty, avoid homework, do they want to play on their own in quiet?)*

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Is there any other important information?

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