CARE PLAN FOR HEARING AIDS

Student's Name: _____ Date: _____

Teacher: _____ Grade: _____

Medical Condition/Diagnosis: _____
_____

Please list what you would like us to do regarding hearing aids:

If: Do this:

1) PE/Recess_____ _____
_____ _____

2) If hearing aid/aids get wet_____
_____ _____

3) Stop working_____ _____
_____ _____

4)_____ _____
_____ _____

Mother's Name: _____
Work Number: _____ Home: _____

Father's Name: _____
Work Number: _____ Home: _____

Physician/Specialist Name and Number: _____

Parent Signature and Date: _____

(Office Use Only) Received by: _____ Date: _____