LAKES DISTRICT HEALTH BOARD

Mobile Ear Clinic Registration Form

Please read both sides.
Parent/caregiver to complete, sign and return to the school office or Ear Nurse.

Please Print the Child's Details		
Childs First Name:	Childs Last Name:	
Date of Birth:	Age:	Please circle: Male or Female
Address:		
Telephone:	Ethnicity:	
School/Preschool:		
Parent/Caregivers Name:	Relationship with child (i.e. Mum/Koro):	
Name of Doctor:		
Any Allergies:		
What is your ear health concern? What would you like us to check?		
Previous Ear Health History		

Informed Consent – Mobile Ear Clinic

I am the Parent/Guardian of _____ (Childs name)

I consent to my child's ears being examined. ❑ **YES** ❑ **NO**

I consent to ear treatment as required until complete. ❑ **YES** ❑ **NO**

I consent to my child's results being shared with their doctor, relevant health professionals and teacher. ❑ **YES** ❑ **NO**

A report will be forwarded to you on any treatment carried out on your child. You will be advised if a further referral is needed.
Please note this is not a hearing test

Signature _____ Date _____
(Parent or legal guardian)

Ear Nurse Specialist
Rotorua: Ph 348 1199 extn 8985 or phone/text 0272 747 542
Taupo: Ph 376 1000 extn 5934 or phone/text 0275 130 930

Information for Parent/Guardian

What Is Ear Examination?

- **Use** of a specialised "torch" (otoscope) to look inside the ear canal to view the eardrum.
- **Tympanometry** - a machine which measures how an eardrum moves indicating fluid in the middle ear.
- **Audiometry** – a machine which indicates the level of hearing in each ear.

What Is Ear Treatment?

Use of microscope and suction equipment to clear wax and/or mucous from the ear canal when:

- the ear has a discharge;
- the child has a failed tympanometry test and wax needs to be removed to examine the eardrum;
- a large amount of wax is blocking the ear canal.

OFFICE USE ONLY – Health History

This section is to be completed by the Ear Nurse Specialist/Public Health Nurse

CHILDS NHI: _____

ORL Specialist: _____ Surgery: _____ Date: _____

ORL Specialist: _____ Surgery: _____ Date: _____

Ear/Hearing Problems: _____

Birth: _____ Developmental: _____

Medical : _____ Hospitalisation: _____

Medication: _____ Referral Source: _____

_____

_____

_____

AUDIOMETRY DATE:					
Right Ear			**Left Ear**		
500Hz	30dB		500Hz	30dB	
1000Hz	40dB or 20dB		1000Hz	40dB or 20dB	
2000Hz	20dB		2000Hz	20dB	
4000Hz	20dB		4000Hz	20dB	
❑ Pass		❑ Fail	❑ Pass		❑ Fail
RESCREEN DATE:					
Right Ear			**Left Ear**		
500Hz	30dB		500Hz	30dB	
1000Hz	40dB or 20dB		1000Hz	40dB or 20dB	
2000Hz	20dB		2000Hz	20dB	
4000Hz	20dB		4000Hz	20dB	
❑ Pass		❑ Fail	❑ Pass		❑ Fail