

PROCEDURES FOR HEARING SCREENING AND FOLLOW-UP EARLY CHILDHOOD SPECIAL EDUCATION HEARING SCREENING

I. General

- A.** Hearing disorders of varying types are prevalent in the preschool population. Studies have reported that up to 80% of children attending day care centers may exhibit frequent ear infections and resulting hearing loss. A hearing screening program for the three (3) to five (5) year old population can assist in identifying the “at-risk” children.

- B.** The following guidelines apply when establishing an early childhood hearing screening program.
 - 1.** Initial screening of children ages 3 - 5 should be completed by appropriately trained personnel. Such personnel may include trained volunteers or school personnel. (For assistance in establishing the hearing screening process, contact the Arkansas Department of Health.)

- C.** Children who fail the initial screening should be re-screened in two to four weeks, due to the many false results of hearing screening which occur at this young age. This second screening should be completed by individuals with increased knowledge of hearing loss. These may include school nurses, speech language pathologists, area services consultants for the hearing impaired, etc.

- D.** Failure of the second screening constitutes an automatic referral for consideration for Early Childhood Special Education Services. Prior to the referral conference, informal observation of the child should be conducted with attention to the following presenting characteristics. The area services consultant for the hearing impaired can provide assistance in this process.
 - 1.** Behavior
 - a.** Frequently uses “neutral response”, “smiling,” saying “yes” and periodically nodding in situations where he/she lacks understanding
 - b.** Has difficulty following verbal directions or does not respond
 - c.** Frequently asks to have statements repeated
 - d.** May appear hyperactive, if he/she is dependent upon monitoring the environment visually and tactually

- e. Is inattentive in group activities
 - f. Appears to be confused, especially in noisy situations
 - g. Gives inappropriate answers to simple questions
 - h. Has complete or partial misunderstanding of conversation
 - i. Is overly dependent on visual clues
 - j. May have a low tolerance for frustration
 - k. Often speaks too loudly or too softly
2. Communication Abilities
- a. Language -
 - i. Difficulty expressing ideas
 - ii. Words frequently omitted from sentences
 - iii. Limited vocabulary
 - iv. Incorrect sentence structure
 - v. Difficulty following directions
 - b. Speech -
 - i. Voice quality harsh, breathy, nasal, and/or monotone
 - ii. Developmentally appropriate sounds distorted and/or omitted from words (i.e., “I caught a fish” may be spoken as “I cau-fi”.)
 - c. Auditory -
 - i. Turns head to one side to hear better
 - ii. Has difficulty in locating source of sounds or speech
 - iii. Responds better to environmental noises than to voice

iv. Has problems understanding speech after a head cold subsides

3. Physical/Medical

- a.** History of frequent earaches or ear discharge, nasal obstruction with associated mouth breathing, or other nasal symptoms, such as frequent colds, sneezing, allergies, history of viral infections, high fever, etc.
- b.** Family history of hearing loss and/or ear diseases
- c.** History of dizziness and balance problems
- d.** Deformity of oral facial structure (i.e., cleft palate)

- E.** If the referral conference decision is that the child is not experiencing developmental difficulties, the conference decision form should reflect that evaluation is not necessary at this time, but that the child's hearing will be screened annually.
- F.** If the referral conference decision is that the child is experiencing developmental difficulties, an evaluation is required, including an otological examination for a child with a history of frequent ear infections.