Special Olympics

HEARING AID MEDICAL CLEARANCE FORM

Athlete Name: _____ Date: _____

Athlete DOB: _____

To Whom It May Concern:

I, _____ (Physician Name, Credential), on _____ (date), medically evaluated the hearing of _____ (Athlete Name), and I have concluded in my medical judgment that _____ (Athlete Name) should (check one of the boxes below):

- ☐ Be considered a candidate for hearing aid(s)
- ☐ Not be considered a candidate for hearing aid(s)

The Athlete and/or their Parent/Guardian, if applicable, is aware of my conclusion and has had an opportunity to ask any questions.

Physician Name (Please Print): _____

License #/Jurisdiction: _____

Signature: _____

Date Signed: _____

Address: _____

_____

_____

Physician Comments (Optional):

_____

_____

_____