2026

Guidelines for School-Aged Hearing Screening

Training Manual

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Contents

This manual is intended for all individuals involved in planning or conducting hearing screenings for school-aged children in Georgia. It outlines best practices and standardized procedures to promote accurate and consistent screening programs across Georgia.

These audiometric hearing screening guidelines were developed for public health and school settings using established national standards, evidence-based practice, and interdisciplinary collaboration. A statewide work group of audiologists in public health, clinical, and school settings led the development, with additional input from external reviewers to ensure clarity and applicability.

The workgroup included:

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Abbreviations

AAA – American Academy of Audiology

AAP – American Academy of Pediatrics

ASHA – American Speech-Language-Hearing Association

CDC – Centers for Disease Control and Prevention

CPA – Conditioned Play Audiometry

dB HL – Decibels Hearing Level (measure of sound intensity)

DPH – Georgia Department of Public Health

FERPA – Family Educational Rights and Privacy Act

Hz – Hertz (cycles per second, measure of frequency)

HIPAA – Health Insurance Portability and Accountability Act

OAE – Otoacoustic Emissions

QA – Quality Assurance

Georgia-Specific References

Form 3300 – Georgia Certificate of Vision, Hearing, Dental, and Nutrition Screening

Rule 511-5-6-.06 – Georgia rule regarding Certificate for Child Exempt from Screenings

O.C.G.A. § 43-44-7(h) – Georgia law permitting OAE screening under certain conditions

I. INTRODUCTION

A. PURPOSE OF SCHOOL-AGE HEARING SCREENING

The primary goal of hearing screening beyond the newborn period is to identify children with late-onset, progressive, or acquired hearing loss, as well as congenital cases that may not have been detected at birth. Early detection is essential to minimize delays in academic achievement, language, and literacy development.

Although permanent congenital hearing loss occurs in approximately 3 per 1,000 live births, the prevalence of hearing loss increases to 9–10 per 1,000 among school-aged children. With timely referral and follow-up, children who are deaf or hard of hearing can achieve outcomes comparable to their hearing peers.

These guidelines are informed by evidence-based practice and national standards, including:

- American Academy of Pediatrics (AAP) *Bright Futures Periodicity Schedule*
- American Academy of Audiology (AAA) *Childhood Hearing Screening Guidelines*

If implementing a universal hearing screening protocol, it is recommended to follow one of the following screening schedules:

- AAP Bright Futures: ages 4, 5, 6, 8, 10, and once during ages 11–14, 15–17, and 18–21 years.
- AAA: preschool, kindergarten, and grades 1, 3, 5, and 7 or 9 (estimated to identify ~70% of childhood hearing loss).

It is recommended to follow the AAA screening guidelines by testing 1000, 2000, and 4000 Hz at 20 dB HL. When completing the Georgia Form 3300, screening requirements include testing at 500 Hz, with a passing level of 20–25 dB HL.

B. RECOMMENDED SCREENING METHOD BY DEVELOPMENTAL AGE

Pure-tone screening with an audiometer remains the gold-standard test method in school-aged children. Otoacoustic emissions (OAEs) screening may be used as a supplemental tool but is not a replacement for pure-tone screening, except under the conditions outlined in Georgia law, O.C.G.A. § 43-44-7(h). OAE testing should be used only when pure-tone screening cannot be performed or is not developmentally appropriate. For OAE screening, Georgia law requires that screening personnel receive appropriate training by a Georgia-licensed audiologist in the use of OAE equipment and interpretation of results.

Table 1: Recommended Hearing Screening Method by Developmental Age

Developmental Age	Recommended Screening Method	Advantages	Limitations
Infancy (0-6 months of age)	Refer to Joint Committee on Infant Hearing 2019 Position Statement		
<3 years	Evoked Otoacoustic Emissions (OAEs)	Quick (<10 minutes) Does not require the child to respond or be conditioned to the task Objective measurement	Should not be used for individuals at risk of Auditory Neuropathy Spectrum Disorder (ANSD) (e.g., NICU graduates, children with significant neurologic history), as OAEs do not assess auditory nerve, brainstem, or cortical function Not a direct test of hearing Very sensitive to middle ear effusion and blockages in the ear canal, which can lead to a high failure rate The child must be quiet and still during the test
3-5 years	Conditioned Play Audiometry (CPA)	Developmentally appropriate "game" approach that engages the child (e.g., placing a block in a bucket when a tone is heard) Provides ear-specific, frequency-specific behavioral thresholds More informative than OAEs once the child is trainable	Relies on cooperation, attention, and understanding of the task Requires practice of the task (i.e., multiple conditioning trials) More time-intensive if conditioning is difficult
5 years – Adolescence	Conventional Pure Tone Audiometry	Gold standard assessment of hearing Tests the entire auditory pathway from the outer ear to the brain	Relies on cooperation, attention, and understanding of the task May take longer in children with behavioral, developmental, or attention differences.

II. HEARING SCREENING PROGRAM FOUNDATIONS

A. ROLES AND RESPONSIBILITIES

- **Hearing Screeners**: Individuals trained to conduct screenings (e.g., nurses, health staff).
- **Audiologists**: While not required by law, audiologist oversight is strongly recommended. Audiologists can assist in selecting screening schedules, reviewing equipment, training screeners, managing referrals, and monitoring program quality.
- **Program Coordinators:** Responsible for implementing screening schedules, managing forms and documentation, notifying families, and maintaining equipment and calibration logs.

B. LEGAL AND ETHICAL CONSIDERATIONS

Programs implementing hearing screening should carefully consider professional liability, risk management, and quality assurance as part of overall accountability. Programs are responsible for understanding and complying with all applicable state, local, and organizational requirements regarding parental permission, exemptions, and documentation.

- **Parental Permission:** Programs must determine when consent is required under their governing policies. In some contexts, routine screenings may not require written permission, while individual or specialized screenings may require parental consent.
- **Religious Exemption:** For the state-mandated initial school entry screening (Form 3300), Georgia Rule 511-5-6-.06 allows families to submit a notarized statement citing religious beliefs. Schools must retain this exemption on file and ensure it is transferred if the child changes schools.
- **Compliance:** Each program is responsible for verifying and adhering to the correct process for consent, opt-out, and exemptions in accordance with applicable law and organizational policies.

C. QUALIFICATIONS OF PERSONNEL COMPLETING HEARING SCREENING

Table 2: Georgia Qualifications of Hearing Screening Personnel by Screening Method

Screening Method	Requirements in Georgia	Who May Perform	Oversight/Training
Pure Tone Audiometry	No statutory requirements.	Trained personnel identified by the facility to perform these screenings	Public Health Staff are required to complete Cox Campus Online Hearing Screening Course and contact Suzanne.Caruthers@dph.ga.gov (Child Health Audiologist) for a hands-on competency check-off (See Appendix E: Online Training and Demonstration Videos)

Screening Method	Requirements in Georgia	Who May Perform	Oversight/Training
			Non-DPH staff should follow their organization's training requirements and are encouraged to complete the Cox Campus course to ensure consistent, high-quality screening practices.
Otoacoustic Emissions (OAE)	Governed by Georgia law O.C.G.A. § 43-44-7(i).	Non-audiologists may perform nondiagnostic, automated OAE screenings only if they complete an audiologist-directed training, use fully automated equipment, report results only as "pass/fail" or "pass/refer"	Must complete training overseen by a Georgia-licensed audiologist.

D. OVERSIGHT AND ACCOUNTABILITY

Effective oversight ensures that hearing screening programs are consistent, reliable, and responsive to children's needs. While Georgia law does not mandate audiologist supervision for pure tone screenings, programs are encouraged to establish structured accountability and quality assurance processes, such as the following:

1. Professional Oversight. Programs are encouraged to engage audiologists or other subject matter experts to support their screening efforts by:

- Developing, reviewing, and updating screening protocols to align with state and national guidelines.
- Advising on selection, calibration, and maintenance of screening equipment.
- Providing initial and refresher training for screeners, including observation and competency checks.
- Consulting on referral management processes and interpretation of program data.
- Reviewing aggregate fail/referral rates to validate the accuracy of screening practices.

2. Data Documentation and Recordkeeping. Programs should maintain clear and organized records to support effective follow-up and program review. Recommended documentation includes:

- Individual results: Document each child's outcome in their health record, on Form 3300 (when applicable), and in program logs. Provide parents with written results.
- Referral logs: Track all children who do not pass, with dates of rescreen, referral, and confirmation of follow-up evaluation.
- Program statistics: Maintain counts of children screened, passed, referred, rescreened, and confirmed follow-up. Summarize quarterly and annually for program monitoring.
- Equipment logs: Complete and store daily mechanical checklists for each audiometer, noting malfunctions and corrective actions.

3. Quality Assurance Metrics. Programs may use the following benchmarks as part of ongoing quality improvement:

- Referral/fail rate: Aim for ≤10%. Consistently higher rates indicate training, equipment, or environmental concerns that require corrective action.

- Follow-up completion: Track follow-up status for children who did not pass the initial screening and consider systems for contacting families when follow-up has not occurred. See Evaluation and Quality Assurance for additional guidance.

4. Continuous Improvement. Programs are encouraged to review performance and adjust over time by:

- Conducting quarterly reviews of program data and logs to identify trends or outliers.
- Providing retraining or protocol adjustments when benchmarks are not met.
- Using findings to refine workflows, such as screening environments, child preparation, or equipment handling.

5. Risk Management and Accountability. Programs should outline local policies for referral pathways, family notification, and documentation to promote consistency and reduce liability.

III. SCREENING ENVIRONMENT

A. SITE SELECTION

An appropriate screening environment is essential for valid and reliable results. Background noise and visual distractions can interfere with children's responses, leading to inaccurate screening outcomes and unnecessary referrals.

- Choose a room that is quiet, isolated from main hallways, and away from high-traffic areas such as cafeterias, gyms, or waiting rooms. Preferred spaces include small offices or conference rooms with carpeting.
- Avoid rooms with hard surfaces and no carpeting, which increase sound reflections.
- Avoid spaces with loud ventilation or nearby HVAC units.
- Ensure that the location has sufficient electrical outlets to accommodate screening equipment needs.

B. BIOLOGIC NOISE LEVEL CHECK

Before hearing screenings can begin, the room must be checked to make sure it is quiet enough. This is called a biologic noise level check. To do this, place the audiometer headphones on an adult with typical hearing. That person should be able to hear the test tones when they are set 10 decibels quieter than the level used for screening children.

For example, the room is acceptable only if a person with typical hearing can hear:

- 500 Hz at 15 dB HL
- 1000, 2000, 4000, 6000, and 8000 Hz at 10 dB HL

If the adult cannot hear these tones at softer levels, the room is too noisy, and screenings must not be conducted there. An alternate, quieter location must be chosen.

IV. EQUIPMENT

A. SELECTING AN AUDIOMETER

Screening programs should use a single-channel audiometer with two earphones. Circumaural or supra-aural headphones are preferred over insert earphones. Because routine hearing screenings typically do not include otoscopy, insert earphones should not be used, as the ear canal cannot be safely inspected prior to insertion. The audiometer should be able to:

- Test frequencies from 500 Hz to 8000 Hz
- Present tones from 0 dB HL to at least 50 dB HL
- Be portable, lightweight, and durable

Many portable audiometers have automatic screening functions, but the use of automatic modes is discouraged in favor of manual operation to ensure accuracy.

B. PERFORMANCE CHECK PROCEDURES

A properly functioning audiometer is critical to avoid inaccurate, failed results. Before beginning each screening session, screeners should complete a mechanical/performance check to confirm that the audiometer is working properly:

- **Power**: Confirm there is power to the audiometer when the equipment is turned on, either by plugging in to a power source or by display of a full battery charge. Check the power cord for signs of deterioration; equipment should not be used with a fraying power cord.
- **Jacks and Cords**: Confirm the headphone and power jacks are appropriately and completely inserted in the equipment receptacles, and the right and left headphones are inserted into the corresponding red (right) and blue (left) receptacles.
- **Earphones**: Confirm that cushions are clean, flexible, and free of cracks; verify the headband has sufficient tension to maintain a snug seal.
- **Changes in Frequency:** Confirm adjusting the frequency corresponds with a change in pitch by presenting a tone at an audible level and cycling through the screening frequencies for each ear.
- **Changes in Volume**: Confirm that adjusting the volume dial corresponds with a change in loudness of the tone by presenting a tone to one ear at a time and increasing and decreasing the volume of the tone. Repeat for the other ear.
- **Tone Presentation Button**: Confirm that the tone presentation button corresponds with the presentation of the screening tone, and the tone presentation ceases when the presentation button is released.
- **Response Button** (if used): Confirm proper function by manipulating the button.
- **Crosstalk**: Confirm no sound is present in the right earphone when you present a sound in the left earphone and vice versa.

Common signs of malfunction include distorted tones, intermittent signals, and indicator lights that do not function correctly. If such issues arise, remove the unit from use until serviced. Any concerns identified during the check should be logged, and the equipment should not be used until issues are resolved. See Appendix A: Performance Check Log

C. ANNUAL CALIBRATION REQUIREMENTS

All audiometers must be professionally calibrated annually. Calibration labels should be affixed to each unit, and schools or facilities should designate staff to track calibration schedules and manage repairs. Headphones cannot be interchanged between units, since each pair is calibrated specifically to its audiometer.

If calibration is out of date or has expired, the audiometer may not be used for screening. Any results obtained with uncalibrated equipment are considered invalid and must be repeated once calibration is restored.

D. CARE AND STORAGE

Proper care and handling of the audiometer are essential to ensure accurate test results and extend the equipment's lifespan.

Handling and Storage

- Handle audiometers carefully; avoid rough treatment or dropping.
- Store the audiometer in a protective case when not in use.
- Keep the device away from dust, dirt, and moisture.
- Avoid exposing the audiometer to extreme temperatures (below 32°F or above 90°F).
- Keep cords untangled and free from pinching or sharp bends.

Cleaning

- Always follow the manufacturer's cleaning and maintenance instructions.
- Generally, surfaces may be wiped with alcohol-free disinfectant wipes, and earphone cushions cleaned with alcohol-free disinfectant.
- Avoid excess moisture, immersion in liquid, and alcohol-based products that can damage cushions or diaphragms (central opening).

V. INFECTION CONTROL

Basic infection control practices are essential to protect both children and screeners during hearing screenings. Screeners should wash their hands or use hand sanitizer before and after each screening. Screeners must cover any open cuts or sores with bandages or wear gloves as needed. Food and beverages should not be allowed in the screening area.

Audiometer headphones and earphones should be cleaned before each use with alcohol-free disinfectant wipes or an approved cleaning agent. Alcohol-based solutions should be avoided, as they can dry out and crack the headphone cushions. Moisture must be kept away from the diaphragm (center opening) of the earphones.

During community lice outbreaks or similar health concerns, facilities should adjust screening schedules or protocols to avoid contributing to the spread of infection.

VI. PRE-SCREENING PROCEDURES

A. RISK FACTORS

Some children are at higher risk for hearing loss and may require closer monitoring or screening beyond the standard schedule. Examples include:

- Family history of permanent childhood hearing loss
- Chronic or recurrent otitis media with effusion
- History of noise exposure (including personal listening devices at high volume)
- Academic concerns such as grade repetition, speech/language delay, or behavioral issues linked to listening difficulties

Documenting these risk factors during case history helps identify children who may benefit from additional screening or referral, even if they pass routine screening protocols.

B. CASE HISTORY

When possible, a brief case history should be obtained prior to screening. The objective is to determine if the child may be at risk for hearing loss or is currently demonstrating signs and symptoms of hearing loss.

Caregivers may be asked about abnormal listening behaviors, speech/language delays, or academic concerns. Children themselves can be asked about ear-related symptoms.

Table 3: Examples of listening complaints and behaviors

COMPLAINTS	BEHAVIORS
Difficulty hearing	Not responding when called; inattentive in class
Difficulty understanding directions	Asks to have things repeated or says "what?" often; watches speakers' lips
Ear pain and/or drainage from ear	Tugs on ear; difficulty sleeping
Fullness in ear or ear "popping"	Tugs or pulls at ear
Ringing in the ear	Shows strain when listening (squints eyes, furrows brow, etc.)
Academic concerns	Difficulty following directions
Articulation difficulties	Unintelligible speech

When completed, notes from the case history should be recorded on the screening form.

C. VISUAL INSPECTION OF THE EAR

Prior to proceeding with a hearing screening, it is important to check the ear for drainage and physical abnormalities. If the child has ear drainage, ear abnormalities such as microtia/atresia (absent or underdeveloped ear and/or ear canal), or if the child wears an amplification device such as a hearing aid or cochlear implant, *the child should not be screened for hearing loss*. Instead, the child should be referred to their medical provider for evaluation of ear drainage and to an audiologist for routine evaluations and management in cases of known hearing loss and physical abnormalities of the ear.

Steps for visual inspection:

- Push back the child's hair to view the pinna and external ear canal area
- Look for redness, swelling, drainage, or structural anomalies (i.e., absence of a canal, low-set ears, extremely small pinna)
- Document any findings on the screening report form

Optional: Otoscopy may be performed by trained personnel using appropriate specula to check for wax, inflammation, or other canal/tympanic abnormalities.

VII. PREPARING FOR THE SCREENING

A. ROOM AND CHILD POSITIONING

Seat the child so they cannot see the audiometer or the screener's hands, typically facing away from the equipment and operator (Figure 1). Minimize visual distractions such as windows, mirrors, or reflective surfaces. For universal screening environments, space screening stations as far apart as possible, provide individualized instructions to each child, and arrange seating to reduce distractions and maintain privacy.

Figure 1: Proper placement with the child facing away from the screener and the audiometer

B. MATERIALS AND DOCUMENTATION

Before beginning, gather all required forms, logs, or checklists for children scheduled for screening. Ensure each record can be completed immediately after the screening to avoid errors or omissions.

C. AUDIOMETER SETUP

After completing the daily mechanical check and biologic listening check, set the audiometer for screening:

1. Use pulsed tones when available, as they are easier for children to distinguish from ambient noise. If not available, steady tones may be used.
2. Ensure headphones are clean and properly adjusted before placement.
3. The red earphone should be placed on the right ear and the blue earphone on the left ear.
4. Remove eyeglasses, headbands, large earrings, or other items that may interfere with headphone placement.
5. The screener should place the headphones on the child, rather than the child placing the headphones on their own ears, and confirm a snug but comfortable fit without gaps between the headphones and the head or sagging of the headphones.

VIII. PURE TONE SCREENING PROCEDURES

A. STANDARD SCREENING PROCEDURE

Introduce the Task: Instruct the child that every time they hear a sound (you may describe it as a "beep"), they should raise their hand. Accept a raised hand (either hand) or other conditioned response as a correct detection.

TIP: Monitoring the child's eyes and facial expressions can help determine the accuracy of responses and the child's continued engagement in the task; however, it is important that the child does not see the screener's hands, the audiometer, or the screening record form. If the child appears to have lost attention to the task, stop the screen and reinstruct the child.

Screen the right ear first, then the left.

Conditioning Tone

Begin with the right ear and present a 1000 Hz pulsed tone at 50 dB HL for 2–3 seconds. This is done to ensure the child understands the task.

- If the child does not respond:
    1. Remove the headphones, instruct the child again, and then replace the headphones.
    2. Repeat the conditioning tone again for 2-3 seconds.
- If there is still no response after reinstruction:
    - If the screener believes the child does not understand the task, proceed to "Conditioned Play Audiometry" (if developmentally appropriate).
    - If the screener believes the child does understand but still cannot hear the tone, the child has failed the screen, and testing should be discontinued.
- If the child responds appropriately by raising their hand, proceed to "Begin Screening."

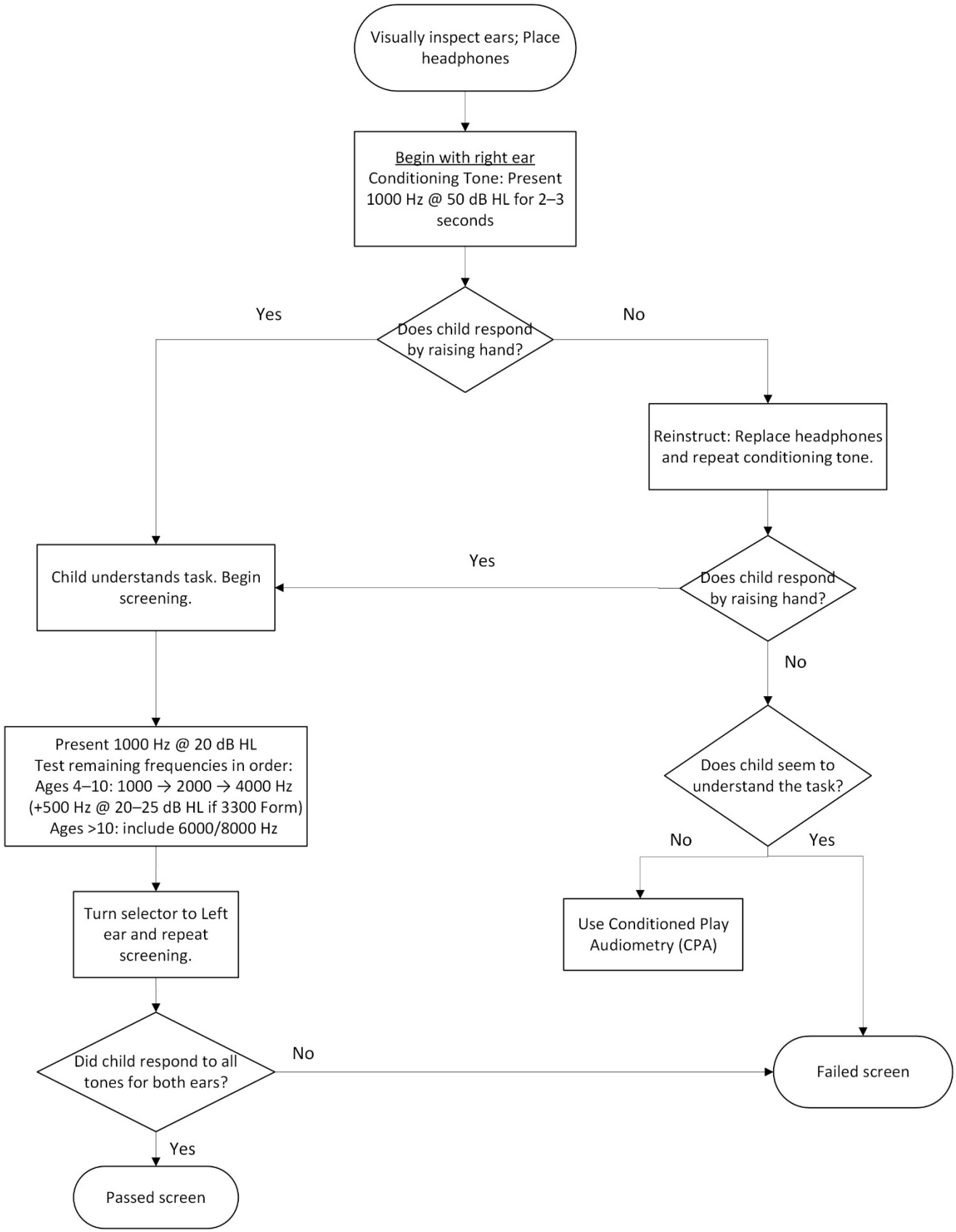
Begin Screening

- Reduce the intensity to 20 dB HL and present the 1000Hz pulsed tone again.
- Record the result for 1000 Hz, then proceed to test the other required frequencies at 20dB HL. Test in order, increase frequency (i.e., 1000 Hz, 2000 Hz, 4000 Hz), and include 500 Hz last if needed (with the option to increase the screening level to 25 dB HL at 500 Hz only).
    - **Ages 4–10**: 1000 Hz, 2000 Hz, 4000 Hz (plus 500 Hz at 20–25 dB HL *if completing* GA Form #3300)
    - **Ages >10**: 1000 Hz, 2000 Hz, 4000 Hz, 6000 Hz, and/or 8000 Hz
- Turn the selector switch to the left ear and repeat the procedure. *Optional:* Tell the child you are changing to the other ear.

Note: Because 500 Hz is the most difficult tone to hear in a screening environment, it should be screened last with the option to increase the screening level to 25 dB HL for 500 Hz only, as allowed by the GA Form #3300.

- If the child responds appropriately to all tones at 20 dB HL in both ears, the child "passed" the hearing screen.
- If the child did not hear one or more tones in either ear, remove the headphones, reinstruct the child, and complete an immediate rescreen, *when possible*, by presenting all tones again at 20 dB HL. *Do not increase the screening level if a child fails to respond*.

Figure 2: Standard Screening Procedure Flow Chart



B. NUMBER OF PRESENTATIONS AND TIMING CONSIDERATIONS

Children often have short attention spans and may miss a tone if there is background noise or a visual distraction. To avoid false responses, do not repeat tones too many times. Each tone should be presented for 2–3 seconds. If the child does not respond, you may repeat it, but no more than three times total, and the timing between presentations should vary.

C. CONDITIONED PLAY AUDIOMETRY (CPA)

CPA is a modified screening procedure appropriate for younger children or children with developmental delays. When using CPA, the child is conditioned to perform a play-based task, such as dropping a block into a bucket, rather than raising their hand when they hear a sound. The purpose of CPA is to use fun and engaging tasks to motivate the child to participate and to incorporate a developmentally appropriate response. The screening levels, test frequencies, and pass/fail criteria remain the same. See Appendix E: Online Training and Demonstration Videos

1. **Set up the environment.** Use a low child-sized table or floor mat to create a comfortable, inviting space.
2. **Introduce the game.** Tell the child they will be playing a listening game with special headphones. Coach them that every time they hear a sound (you may describe it as a "beep" they should drop their block into the bucket.
3. **Demonstrate the task.** Hold a block near your ear and model listening behavior (quiet, expectant expression). Present a louder conditioning tone at 50dB HL for 1000 Hz, then show a positive response by dropping your block in the bucket and saying, "I heard it!" Give the child their own block to hold and guide them through the same action.
4. **Condition the child.** Repeat the conditioning tone as needed. If the child does not respond independently, guide their hand to drop the block. The goal is for the child to consistently drop the block independently each time the tone is heard.
5. **Respond to approximations.** If the child shows a partial response (such as turning their head, shifting eyes, or smiling), remind them that the correct response is to drop the block in the bucket.
6. **Fade adult participation.** Once the child responds consistently, stop participating yourself and cue the child with encouragement (e.g., "Okay, all by yourself now!").
7. **Proceed to standard screening**. Lower the presentation level to 20 dB HL and follow the standard protocol for test frequencies. At this point, the child must independently drop the block in the bucket to count as a positive response. Maintain a neutral expression and avoid prompting during testing.

Helpful Tips:

- Reward the child with verbal praise after the first correct responses and continue to encourage them throughout the screening.
- If the child resists headphones, let them watch another child or a family member participate first to reduce anxiety.
- Alternative activities may be used (e.g., placing pegs in a pegboard or putting pieces on Mr. Potato Head). The game should remain simple, quick, and engaging.
- If you are concerned with false positive responses (i.e., the child responds before the tone has been presented), include a few "blank" or control presentations – simulate giving a stimulus trial without

actually providing the tone. If the child responds to a blank trial, you may be providing visual or timing cues inadvertently

See example video demonstrating CPA in Appendix E.

D. COMMON ERRORS TO AVOID

- Fatigue caused by extended screening time. Each child fatigues during screening at a different rate, depending on factors such as age, attention span, and interest in the task.
- Rushed screening process.
- Inaccurate or unclear directions to the child, such as providing instructions in a non-native language or by using words that are not developmentally appropriate for the child.
- Child in direct view of the audiometer control panel or the motions of the screening personnel.
- Earphone on the incorrect ear.
- Gapping or sagging of the headphones on the head.
- Visual cues given through eye movement or body movement of screening personnel.
- Repeating tone presentation more than the maximum number of recommended presentations (3) when the child does not respond.
- Tone presentation in a rhythmic manner or at predictable time intervals.
- Unnecessary talking or background noise during screening.
- Adding pressure by holding down the headphones during screening; this may collapse the ear canals and temporarily affect hearing sensitivity.
- Screening a child with known hearing loss who wears an assistive listening device. These children should not be screened; instead, they should be referred to their care team (i.e., audiologist, medical provider, and/or appropriate school personnel).

IX. SCREENING OUTCOMES

A. PASS CRITERIA

Child hears *all* required screening-frequency tones at 20 dB HL in both ears (25 dB *HL is allowed at 500 Hz)*.

B. FAIL/REFER CRITERIA

Missing even one tone in either ear constitutes a failed screen.

Children with ear drainage, structural abnormalities, or amplification devices should bypass screening and be referred directly.

C. IMMEDIATE RESCREEN PROCEDURES

If a child does not respond to one or more tones during the initial screening, conduct a rescreen. An immediate rescreen helps confirm whether the initial failure was due to positioning, attention, or understanding and can reduce referral rates by 25–50%.

- Remove the headphones, re-instruct the child, and ensure proper headphone placement.
- Repeat the full screening protocol immediately, using the same presentation levels (do not increase the dB level).

Optional: Some programs choose to have a different screener or audiometer conduct the immediate rescreen to minimize error.

D. SCHEDULED RESCREENS (2-WEEK PROTOCOL)

A follow-up screening should be scheduled approximately 2 weeks later to allow time for temporary conditions such as ear infections, congestion, or fatigue to resolve. The rescreen must follow the same protocol and criteria as the initial screening. If the child does not pass the scheduled rescreen, they should be referred to their medical provider and/or an audiologist for further evaluation.

X. REFERRAL AND FOLLOW-UP

Screening is only effective if children who do not pass receive timely referrals and evaluations. Without follow-up, children remain at risk for undiagnosed hearing loss and its educational, developmental, and social consequences. See Appendix B: Audiological Resources for a map of Georgia-licensed audiologists.

A. REFERRAL PROCEDURES

Children who do not pass the final screening or rescreen should be referred to their medical provider and/or an audiologist for diagnostic testing. For children with known ear drainage or structural abnormalities, screening should be bypassed and a direct referral made to the appropriate provider. Families should also be given clear written instructions and educational resources that explain the importance of follow-up care.

B. PARENT/CAREGIVER COMMUNICATION

Parents should receive screening results in both written and verbal form, and results should always be provided in the parents' preferred language. Families should also be encouraged to share results with the child's medical home. When feasible, programs are encouraged to follow up with caregivers to confirm that referrals have been completed.

It is important that screening results and referral information be presented to the family, and that information describing childhood hearing loss be included.

C. COLLABORATION WITH LOCAL PROVIDERS

Schools and screening programs should build relationships with local medical and audiology providers to improve the referral process. Sharing information about screening criteria and procedures helps providers

understand the program and encourages them to return evaluation results to the school or screening program for tracking.

D. STRATEGIES TO REDUCE LOSS-TO-FOLLOW-UP

Programs can reduce loss-to-follow-up by conducting immediate rescreens when possible, providing same-day written results to families with clearly defined next steps, and maintaining a contact log for children needing further evaluation. Clear and simple communication can also help reduce confusion and improve family compliance with follow-up recommendations.

XI. DOCUMENTATION & REPORTING

Accurate and consistent documentation is essential for ensuring the effectiveness of hearing screening programs and for maintaining compliance with state and federal requirements.

A. DOCUMENTATION

1. Results of the screening should be documented in the child's record and on the GA DPH Form #3300 when appropriate.
2. The GA DPH-approved Pediatric Hearing Screening form is openly accessible to any facility/school and can be found in Appendix D: Forms.
3. Parents should receive notice of the hearing screening results in writing and verbally in their native language.
4. Designated staff for the facility/school should retain a copy of the screening results.
5. Each facility/school should follow its designated protocol for rescreening and parental notifications.
6. *Encouraged:* Send a copy of the hearing screen results to the child's primary medical provider.
7. *Optional:* Facilities/schools are encouraged to follow up with caregivers to ensure appropriate medical referrals were completed.
8. *Optional:* Facilities performing universal screenings can maintain a log of children screened and their results.

B. TRACKING AND RECORD-KEEPING

Programs should maintain a log of children who do not pass a screening or rescreen until documentation of follow-up is received. If no follow-up is reported within the designated timeframe, programs should attempt to re-contact the family. Each record must include the child's full name, date of birth, date and type of screening, school and grade, screener's name and signature, and any relevant case history notes.

Programs are responsible for retaining screening forms in accordance with state, local, and legal requirements. Programs should consult the Georgia Archives Local Government Record Retention Schedules and any applicable regulations to ensure compliance.

All records must comply with confidentiality requirements under the Health Insurance Portability and Accountability Act (HIPAA) and/or the Family Educational Rights and Privacy Act (FERPA). Programs should ensure staff are trained in the handling of student health records to protect privacy.

C. EVALUATION AND QUALITY ASSURANCE

Screening for pediatric hearing loss is a serious undertaking that requires intermittent program evaluation by a program manager to assess the effectiveness and efficiency of the current screening process. AAA recommends developing mechanisms to: (a) quantify the pass and refer rates, (b) estimate the false-positive and false-negative screening rates (i.e., sensitivity and specificity), and (c) assure the effectiveness of follow-up protocols for children who need rescreening or are referred for additional testing. Program evaluations should be ongoing and occur formally *at least annually* to identify and adjust factors that hinder program performance and efficiency.

Types of information needed to determine the program's effectiveness include the following: (adapted from Johnson and Seaton, 2011 by AAA):

At least annually, programs should review data to assess:

- Total number of children screened
- Number and percentage who did not pass the initial screening
- Number and percentage who missed screening (absence, parental refusal, other reasons)
- Number and percentage who did not pass rescreening
- Number and percentage referred for further evaluation (audiological, medical, educational)
- Number and percentage who completed follow-up evaluations
- Number and percentage diagnosed with hearing loss
- Number and percentage provided treatment or educational services (including amplification or assistive devices)

These data help programs estimate false-positive and false-negative rates, monitor follow-up success, and evaluate overall screening effectiveness. Programs are also recommended to monitor overall fail rates when feasible, which should remain below 10%. Higher rates may indicate the need for retraining, equipment checks, or review of screening procedures.

Audiologists can play a key role in analyzing program data and providing recommendations for quality improvement.

XIII. REFERENCES

American Academy of Audiology. (2011). *Childhood hearing screening guidelines*. Reston, VA

American Academy of Pediatrics. (n.d.). *Bright Futures periodicity schedule*. Retrieved from https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

Bower, C., Reilly, B. K., Richerson, J., Hecht, J. L., Committee on Practice & Ambulatory Medicine. (2023). Hearing assessment in infants, children, and adolescents: Recommendations beyond neonatal screening. *Pediatrics, 152*(3), e2023063288. https://doi.org/10.1542/peds.2023-063288 PubMed+1

Centers for Disease Control and Prevention. (2024). *Head lice information for schools*. U.S. Department of Health and Human Services. Retrieved from https://www.cdc.gov/parasites/lice/head/schools.html

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XIV. APPENDICES

APPENDIX A: PERFORMANCE CHECK LOG

Audiometer Performance Check Log		
Audiometer Serial Number	**Audiometer Serial Number**	**Last Professional Calibration Date**

Before each use: Complete a performance check using the descriptions below prior to using the audiometer. Enter the date of the performance check, examiner's name, and check each box to verify appropriate function. If the audiometer does not pass any portion of the performance check, it should not be used for testing until it has been professionally evaluated.

Date	**Examiner**	*Power On*	*Jacks Seated*	*Earphone Cushions Intact*	*Dials Tight*	*Headband Tension*	*Cords Intact*	*Changes in Volume*	*Changes in Frequency*	*Presentation Button*	*No Cross Talk*	*Response Button (if used)*
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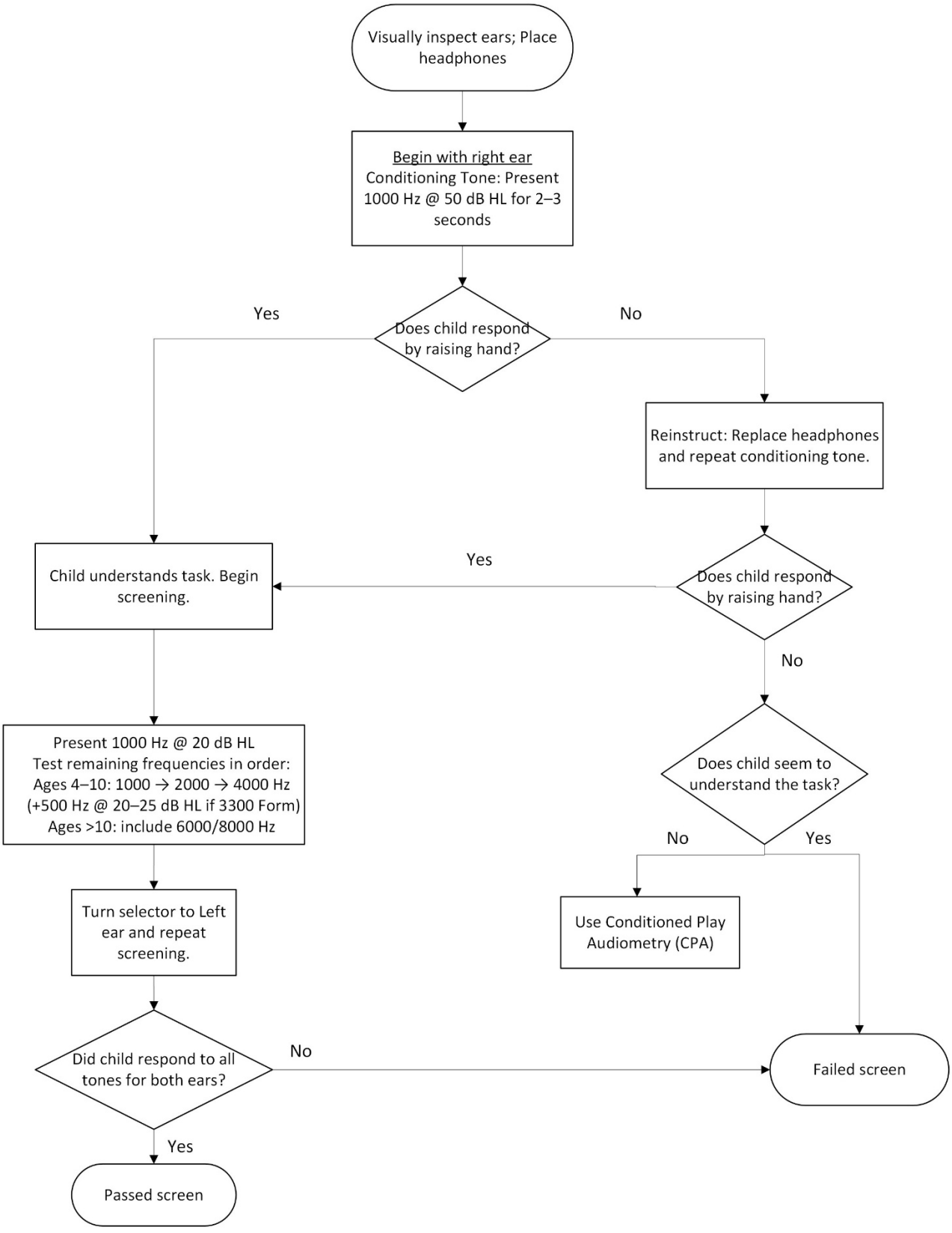
APPENDIX B: STANDARD SCREENING PROCESS FLOWCHART



APPENDIX C: AUDIOLOGICAL RESOURCES

Map of Audiologists in Georgia who See Children
Hearing Aid Resource List

APPENDIX D: FORMS

Georgia DPH Form 3300
Georgia DPH Pediatric Hearing Screening Results form

APPENDIX E: ONLINE TRAINING AND DEMONSTRATION VIDEOS

Cox Campus Pediatric Hearing Screening Training Module – Free online training resource for OAE and pure tone audiometry

University of Canterbury – Department of Communication Disorders – Child Hearing Test – Helpful video showing Conditioned Play Audiometry.

Pure Tone Technique, Dr. James Hall – Helpful video showing pure tone audiometry

APPENDIX F: PROFESSIONAL GUIDELINES

American Academy of Pediatrics (AAP) – Hearing Assessment in Infants, Children, and Adolescents: Recommendations Beyond Neonatal Screening

American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule

American Academy of Audiology (AAA) Childhood Hearing Screening Guidelines

American Speech-Language-Hearing Association (ASHA) Guidelines

Clinical Practice Guidelines: Childhood Hearing Screening - American Academy of Audiology

Joint Committee on Infant Hearing (JCIH) 2019 Position Statement

Georgia Department of Community Health – Policies and Procedures for Early & Periodic Screening, Diagnostic, and Treatment (EPSDT) Health Check Program

APPENDIX G: USEFUL LINKS (AAA, ASHA, AAP, GEORGIA DPH RESOURCES, HIPAA/FERPA, LAWS)

FERPA-Protecting Student Privacy
Georgia Law Regarding OAE Screening
How to Become HIPAA Compliant
Local Government Record Retention Schedules | Georgia Archives
Rule 511-5-6-.06. Certificate for Child Exempt from Screenings

GEORGIA DEPARTMENT OF PUBLIC HEALTH