NEST

Network for Empowerment, Support & Training

Family Enrollment Form

Family Name: _____

Name of Child with Hearing Loss: _____

Birthdate: _____ Age at Diagnosis: _____

Birthing Hospital: _____ Newborn Hearing Screening: _____

Child's Hearing loss is categorized as: Bilateral Unilateral

Conductive Sensorineural Mixed *not confirmed

Mild (25-40dB) Moderate (40-55dB) Moderately Severe (55-75dB)

Severe (75-90dB) Profound (90dB+)

My Child Currently: Wears Hearing aids Has a cochlear implant(s) Wears a BAHA

Is in the Cochlear Implant process Other:_____

Family History of hearing loss: _____

Significant Birth history/diagnosis:_____

Siblings living in the home (ages):_____

Family Address: _____ Email:_____

_____ Phone number:_____

School System: _____ Enrolled in Early Intervention:_____

Audiologist: _____ Speech therapist/LSL AVT:_____

I preferer to receive contact via: email text phone/voice message

The best time to reach me: mornings____ evenings____ weekends_____