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SPEECH AND LANGUAGE CONSENT FORM

I, the parent (guardian) of _____, born _____,
 (Name of Child) (DOB: year/month/day)

hereby give my consent for the Speech-Language Pathologist

to see and evaluate this student. I understand that I have the right to be fully informed as to the results of the evaluation and/or any ongoing service that may be provided.

The name of the family physician is _____.

Is your child currently, or has he or she in the past, received services from a

- Ears, Nose and Throat (ENT) Specialist
- Audiologist
- Psychologist
- Speech-Language Pathologist
- Occupational Therapist
- Physiotherapist
- Allergist
- Counsellor
- Other: _____

If yes, Who _____

Reason _____

When _____

Has your child had a History of middle ear infections Age _____

Tubes in ears Age _____

 Signature of Parent or Guardian

 Date