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**PARENT/GUARDIAN CONSENT – SPEECH-LANGUAGE PATHOLOGY SERVICES**

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| Student’s Name:       Date of Birth (m/d/y):  School:       Grade: |

Parent/Guardian(s):

Address:

I hereby give permission for Chase to receive any of the following Speech-Language Pathology service(s) as deemed necessary.

1) Assessment/Evaluation ☐

2) Consultation ☐

3) Speech-Language Therapy ☐

4) Home Program ☐

5) Hearing Screening ☐

I consent to       receiving the above indicated Speech-Language services and I understand that the involved school staff may be consulted, and will receive information regarding the results/services.

Parent/Guardian Signature: Date:

☐ Copy Sent to Confidential File