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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