South Shore
Regional Centre for Education

PARENT/GUARDIAN CONSENT – SPEECH-LANGUAGE PATHOLOGY SERVICES

Student's Name:	Date of Birth (m/d/y):
School:	Grade:
Speech-Language Pathologist:	Date sent:

Parent/Guardian(s): _____

Address (if different than one provided in school file):

_____

_____

_____

Phone: _____

E-mail: _____

I hereby give permission for _____ 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.

Speech-Language Pathologists are following individual school plans as well as Public Health protocols to ensure the health and safety of <u>all</u> students across various communities.

Parent/Guardian Signature:_____

Date: _____

☐ Copy Sent to Confidential File