



HIGH FIVE SPEECH THERAPY

PEDIATRIC SPEECH + LANGUAGE + FEEDING THERAPY

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SCREENING PERMISSION FORM

If you would like your child(ren)'s speech, language and social skills to be screened by High 5 Speech Therapy, please complete the info below and return by the date specified by your child's program.

Note: Screening results are confidential and will only be shared with non-guardians with written permission from guardian.

Guardian Full Name:

Cell Phone Number:

Email:

High 5 Speech Therapy will be in touch soon with scheduling details and a case history form.

How would you like to be reached?

 Text Email

Child(ren) To Be Screened:

Child's First & Last Name	Child's Age & Birthdate	Student's Status at Dragonflies Discovery Preschool
		<input type="checkbox"/> This child attends this school. Class: _____ <input type="checkbox"/> This child is a sibling of a student at this school. Full name of sibling who attends this school: _____
		<input type="checkbox"/> This child attends this school. Class: _____ <input type="checkbox"/> This child is a sibling of a student at this school. Full name of sibling who attends this school: _____
		<input type="checkbox"/> This child attends this school. Class: _____ <input type="checkbox"/> This child is a sibling of a student at this school. Full name of sibling who attends this school: _____
		<input type="checkbox"/> This child attends this school. Class: _____ <input type="checkbox"/> This child is a sibling of a student at this school. Full name of sibling who attends this school: _____
		<input type="checkbox"/> This child attends this school. Class: _____ <input type="checkbox"/> This child is a sibling of a student at this school. Full name of sibling who attends this school: _____

I, _____ give permission for my child(ren) to
Printed Name of Guardian

participate in a speech/language screening with High 5 Speech Therapy.

X

Signature of Guardian

Date