Capitol City
Speech Therapy, LLC

141 N Main Street
Fuquay-Varina, NC 27526

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Permission to Screen

Child's Name:_____Date of Birth:_____

Name of Childcare Center: _____/Name of Class:_____

Parent's Name:_____ Email:_____

Telephone Number:_____(home)

_____(Mother's number)

_____(Father's number)

Teacher's Name:_____

Do you have any specific concern(s) about your child's speech and language skills? If so, what specific concern(s) do you have?

_____

_____

_____

I give permission to Capitol City Speech Therapy, LLC to screen my child for speech and language skills and hearing.

_____

(Parent/Guardian) (Date)

I give permission to the Speech/Language Pathologist or Assistant from Capitol City Speech Therapy, LLC to discuss the results of this screening with personnel (teacher, teacher's assistant and/or director) at my child's daycare/preschool center.

_____

(Parent/Guardian)

Updated 1/12/2015