141 N Main Street
Fuquay-Varina, NC 27526

1520 Glenwood Avenue, Suite 201
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Office: 919-577-6807 Fax: 919-577-6853
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Permission to Screen

Child's Name: ____ Date of Birth: ____________

Name of Childcare Center: ______________________________ Name of Class: ____________________

Teacher's Name: ____

Parent/Guardian Name: ____

Email: ____

Telephone Number: _______________________________ home/work/cell

_______________________________ home/work/cell

_______________________________ home/work/cell

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) (Date)