Capitol City
Speech Therapy, PLLC

Fax: 919-577-6853
Office: 919-577-6807
www.ccst.coach

Permission to Screen

Child's Name: _____ Date of Birth: _____

Name of Childcare Center: _____

Teacher's Name: _____Name of Class:_____

Parent/Guardian Name: _____

Email: _____

Telephone Number: _____ home/work/cell

_____ home/work/cell

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

_____

_____

I give permission to Capitol City Speech Therapy, PLLC 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, PLLC 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)

1330 St. Mary's Street, Suite 100
Raleigh NC 27605

141 North Main Street
Fuquay Varina, NC 27526