



PERMISSION TO SCREEN/EVALUATE

I, _____, give permission for my child _____ to be screened by Verbal Expressions, Inc. to determine possibility of a speech-language disorder(s).

I understand that if my child is found to show signs of a possible speech-language disorder, he/she will receive a comprehensive evaluation and subsequent therapy after his/her primary care physician has given approval. If services cannot be provided by Verbal Expressions, Inc., your child will be referred to a qualified speech-language pathologist for additional assistance with your permission.

Signature of Parent/Guardian

Print Name

Child's Name (Please Print)

Date of Birth

Telephone No.

Address

City

State/ Zip Code

Email Address

Primary Care Physician

Telephone No.