My Therapy Solutions  
 Consent to Screen

346-515-0370

[www.mytherapysolutionsusa.com](http://www.mytherapysolutionsusa.com)

info@mytherapysolutionsusa.com

Date:   
  
Student Name:  
  
DOB:   
  
Preferred Phone Number:  
  
Languages Spoken at Home:

Teacher:   
  
Grade:  
  
Has your child received therapy services (speech, OT, PT) before? yes/no  
If yes, please elaborate:   
  
Do you have any concerns with the area of (speech/language or OT)?yes/no  
If yes, please elaborate: This form constitutes a request for a speech/OT screening, with parent/guardian permission, to determine if a special education referral is needed. This screening will include a review of the student’s (speech articulation, fluency or voice, fine motor). This screening will be completed virtually using a secure meeting platform. Results will be shared with parent(s) and teacher(s) to determine a plan of action. A copy will be placed in the speech-language specialist’s temporary file.  
 ❐I do give consent to conduct a speech screening.   
 ❐ I do not give consent to conduct a speech screening.   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_  
**Parent/Guardian Signature Relationship to Child Date**