



RENFREW COUNTY CATHOLIC DISTRICT SCHOOL BOARD REQUEST FOR CONSENT TO PROVIDE SPEECH-LANGUAGE SERVICES

TO: _____
Parent, Legal Guardian, or Student Name of Student

Address:

(yyyy-mm-dd)

Your child has been referred to our school speech-language pathologist for a consultation. The speech-language pathologist may observe your child in the classroom, provide programming suggestions to his teacher or conduct an assessment of your child's speech and language skills.

Information obtained may be helpful in understanding your child's development and assist the school in meeting his educational and social needs. Background information about your child may be included in the process. The speech-language assessment may include:

- Review of school records
- Classroom observation
- Communication with teacher/parent
- Evaluation of oral language processing and ability to follow instructions, memory
- for information, understanding and use of word meanings, use of age appropriate speech sounds and grammar, oral structure and movement.

All results of testing will be discussed with you and with school staff involved with your child. If speech-language treatment is indicated, you will be asked to give your verbal permission to proceed with further speech-language programming. A written report of the speech-language assessment will be maintained in a confidential file in the Ontario Student

Record (O.S.R.) A copy of the report will be retained by the author of the report, and a copy will be provided to you and to the communication disorders facilitator (if providing the intervention). No information will be released concerning speech-language services provided to the above-named student to any person outside the RCCDSB without your informed written consent.

In signing this permission form, you acknowledge the use of the results for educational programme developmentI fully understand the nature of the speech-language services to be provided and the reason(s) for this service.

I agree to the collection, use, and disclosure of personal health information involved in this service.

I give my permission for the above service to be provided.

Signature of Parent, Legal Guardian, or Student
(if over 16 years of age)

Date