

(KG)

# Al Mustafa Academy & Humanitarian Society

## PARENT CONSENT FOR SPEECH, LANGUAGE, OCCUPATIONAL AND PHYSICAL THERAPY SERVICES PRESCHOOL AND KINDERGARTEN ONLY

As part of the services offered by your child's school, all children's speech and language skills will be screened. The occupational therapist and when necessary, the physical therapist may also screen the students

Student's First Name:

Home Phone Number:

Date of Birth: Gender: Male Female

Student's Last Name:

Mother Name:

Cell Phone:

Father Name:

Cell Phone:

1) Was your child born in Canada? Yes No in \_\_\_\_\_

2) What language does your child speak the most at home? \_\_\_\_\_

3) Do they speak another language at home as well?  
\_\_\_\_\_

4) What language does your child understand best? English Other \_\_\_\_\_

5) When you speak to your child in your native language, do they answer in English? Yes No

6) Has your child participated in any community activities like swimming or soccer? Yes No

7) Does your child have older brothers and sisters? Yes No

8) Do brothers and sisters speak to him/her in: English Other Language Both

9) When playing with friends/family, what language is your child speaking? English Other-Please specify: Both

# Al Mustafa Academy & Humanitarian Society

10) Does your child watch TV in English Other Language Both

11) Do you read to your child in English Other Language Both

12) Did your child attend preschool? Yes No Currently attending

How many years? \_\_\_\_\_ Where? \_\_\_\_\_

13) Did your child attend daycare? Yes No How many years? \_\_\_\_\_

14) Has your child been assessed by any specialist such as a speech language pathologist or occupational therapist? Yes No

Who did they see? \_\_\_\_\_

15) At what age did your child say their first words? \_\_\_\_\_

In what language? English Other \_\_\_\_\_ (Specify).

I give permission for my child to receive services from the speech language pathologist, occupational therapist and/or physical therapist contracted by the school. This will include being screened by the speech language pathologist, occupational therapist and/or physical therapist and receiving follow up assessments and treatment, if necessary. I give my permission for the speech language pathologist, occupational therapist and/or physical therapist to request reports and information from my child's previous school, if needed. In addition, the speech language pathologist, occupational therapist and/or physical therapist may access information from my child's current school records and obtain information from other professional agencies, when required.

**I confirm that all of the information provided in this agreement is accurate and complete.**

Signature of Parent or Guardian \_\_\_\_\_

Date: DD / MM / YYYY