Permission to Screen

SPARTANBURG COUNTY SCHOOL District 6

Student's Name:_____ School:_____ Date:_____

Date of Birth:_____ Grade:_____ Teacher:_____

Parent/Guardian:_____Telephone (home)_____(work)_____

Address:_____

Dear _____, per our discussion at our most recent conference, we would like to
(Parent/Legal Guardian/Surrogate Parent)
complete the following screenings with your child. Screening results will be used to assist in providing your child with the most appropriate strategies and support at school. The results of any screening information collected will be shared with you, as well as any other information we have agreed to collect together. We welcome your input in developing strategies to help your child become more successful in school. We would like to collect information in the following areas:

Date of Conference that the following screenings were explained: _____

- ☐ vision screening
- ☐ hearing screening

Date of Conference that the following screenings were explained: _____

- ☐ speech-language screening
- ☐ observations of the student in a setting(s) related to the referral concerns
- ☐ Processing Screenings
- ☐ Academic Screenings
- ☐ social/developmental history data from parent or primary caregiver
- ☐ behavioral checklists;
- ☐ other (Describe: _____)

These screenings may be conducted by a school nurse, speech/language therapist or other professional school staff. If you have any questions or concerns you can reach your child's teacher or another team member at _____.
(Name and Number of Contact Person)

PLEASE CHECK & SIGN AND RETURN TO YOUR CHILD'S SCHOOL

_____I **give** permission for my child to be given the screenings indicated above.

_____I **do not** give permission for my child to be given the screenings indicated above.

Parent/Guardian Signature _____ Date:_____

I am the (check one):
( ) Parent
( ) Legal Guardian
( ) Surrogate Parent