MONTGOMERY TOWNSHIP SCHOOLS
1014 ROUTE 601 • SKILLMAN, NJ • 08558• PHONE (609) 466-7601 • FAX (609) 466-0944
Office of Special Services

SPEECH SCREENING REQUEST FORM

Date: _____

Student: _____ DOB: _____

Teacher: _____ Grade:_____ Languages spoken at home: _____

Parent(s): _____ Phone: _____

Parent(s) email: _____

Has your child previously received speech-language services? _____

This form constitutes a request for a speech 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, and/or voice. 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.

MTSD must have documentation to indicate that your child has passed a hearing and vision screening prior to receiving a speech screening. Upon receiving this Speech Screening Request, a hearing/vision form will be submitted to the school nurse.

Reason for Screening Request: (check all areas of concern)

- □ Speech articulation/pronunciation
- □ Fluency/stuttering
- □ Voice differences (e.g., hoarseness, hypernasality, pitch, rate, volume)

Comments (Please provide specific examples to support request)

_____

_____

- □ I **do** give consent to conduct a speech screening.
- □ I **do not** give consent to conduct a speech screening.

_____ _____ _____
Parent/Guardian Signature **Date**

_____

Building Use Only

Date Request Received _____

Date of Screening _____

Speech-Language Specialist _____

Results: Pass Rescreen Referral Recommended