

NOVA SOUTHEASTERN UNIVERSITY
CLINICS IN AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

Permission to Observe/Assess Client in School

Client: _____ Date of Birth _____

Parent's or Spouse's Name: _____

Address: _____

As a part of the speech-language services provided by Nova Southeastern University's Clinics in Audiology and Speech-Language Pathology, I give permission for faculty and/or graduate students to observe my child in his/her school setting, and review his/her educational records, Individualized Education Plan (IEP), and speech-language therapy reports. If photocopies of any of these documents are needed, I give my consent to have them copied and placed in my child's records at the Clinics in Audiology and Speech-Language Pathology. It is understood that the faculty and students will consider any information revealed during such examinations or demonstrations as privileged communications will hold such information in confidence, except when authorized by me (us) to release it to appropriate medical, social, educational, health or other agencies.

School Name: _____

Teacher's Name: _____

Speech-Language Pathologist's Name: _____

This form has been fully explained to me (us) and I (we) certify that its contents are understood.

(Family Member's or Client's Signature)

(Date)