

## Welcome to The Speech and Language Center Social Skills Group

The social skills preschool program focuses on intense speech and language therapy embedded in a preschool structure. Integration of typically developing same aged peers are incorporated into each session to further enhance the peer model influence. All therapy is in a small group, play based and incorporates all areas of development. Each child will have goals for expressive language, receptive language, cognitive skills, social skills, play skills and literacy development. These goals will be addressed in a small group setting led by a licensed Speech Language Therapist (4 children for 1 therapist).

Our sessions are focused on a whole child approach; while speech and language is targeted, all activities will involve skills which enhance gross motor skills (song and dance), fine motor skills (art and crafts) and sensory integration.

Each child will be screened in all areas of development: those screenings may indicate the further need for therapy services. These screening tools are used to identify potential signs/need areas for further evaluation. This is simply a recommendation not a requirement. We are happy to answer any questions you may have regarding those screenings. Your child's first comprehensive screening will be within the first 4 weeks of session. At that time all caregivers will be invited to discuss those screenings and add any information/goals that they may have.

Like us on Facebook! We love to share pictures (with permission) and updates on what we are learning/doing at the center. This is a great way to see your child in action.

Contact us with any questions/concerns at any time. Our email is: [info@thespeechlanguagecenter.com](mailto:info@thespeechlanguagecenter.com)

Items included in this packet include:

- \_\_\_\_\_ Intake Form
- \_\_\_\_\_ Authorization for medical attention
- \_\_\_\_\_ Consent for treatemnt
- \_\_\_\_\_ Policy and Procedures
- \_\_\_\_\_ Photo Release
- \_\_\_\_\_ Privacy Practices

Please return all items prior to your child's start date. Your child is scheduled to start on: \_\_\_\_\_

## The Speech and Language Center Intake Form

### I. Identifying Information

Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_

Child's Home Address:

\_\_\_\_\_  
(Street, City, State, and Zip)

Name of Parent/Guardian \_\_\_\_\_

Relationship to child \_\_\_\_\_

Occupation: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work or Cell ( ) \_\_\_\_\_

Email \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Address (if different than above): \_\_\_\_\_

Occupation: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work or Cell ( ) \_\_\_\_\_

Email: \_\_\_\_\_

Who does your child live with? (Check all that apply.)

- both parents                       grandparents                       mother only                       foster parents  
 father only                       parent + stepparent     other \_\_\_\_\_

Are languages other than English (including sign language) used at home? \_\_\_\_\_ yes \_\_\_\_\_ no

If Yes, what language (s)? \_\_\_\_\_

Preferred method of contact for communications, notifications and announcements.

\_\_\_\_\_ Text: Phone number preferred: \_\_\_\_\_ Email \_\_\_\_\_ Call

### II. Referral/ Insurance info

How did you hear about our program? \_\_\_\_\_

Do you have concerns about your child's speech and language development? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, please explain here: \_\_\_\_\_

Is/Has your child received speech/language and/or developmental services? \_\_\_\_\_ yes \_\_\_\_\_ no

Has your child been evaluated by any other professional? (Check all that apply.)

- Speech-language pathologist                       educator/teacher  
 Occupational therapist (OT)                       neurologist  
 Physical therapist (PT)                       physician  
 developmental pediatrician (specialist)     geneticist  
 psychologist/psychiatrist     other \_\_\_\_\_

Any other relevant evaluations? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, please list \_\_\_\_\_

\*Please provide us with a copy of any evaluation reports you may have.\*

Boone County Family Resources Service Coordinator, if applicable: \_\_\_\_\_

First Steps Therapist and Service Coordinator: \_\_\_\_\_

Insurance: Medicaid: yes or no/ If yes, what type: \_\_\_\_\_

Medicaid DCN#: \_\_\_\_\_

Do you also have private insurance? Yes / No

Name of Insurance Company: \_\_\_\_\_

Policyholder name:: \_\_\_\_\_

Policyholder Date of Birth: \_\_\_\_\_

Policyholder ID # or SSN: \_\_\_\_\_

Group #: \_\_\_\_\_

On the back of the card: Provider phone #: \_\_\_\_\_

### III. Home and Family

Please list siblings and other members of the household (not listed on page 1) :

Name, Date of birth, Age, M/F, Relationship to child

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Do any of the above individuals have speech, language or hearing problems? \_\_\_\_yes \_\_\_\_no

If yes, please explain: \_\_\_\_\_

Are there any other family members (grandparents, cousins, etc) that have a hearing loss or communication problem? \_\_\_\_yes \_\_\_\_no

If yes, please explain: \_\_\_\_\_

### IV. Prenatal (pregnancy) and Birth

Mother's date of birth \_\_\_\_\_

Father's date of birth \_\_\_\_\_

Length of Pregnancy in weeks: \_\_\_\_\_

Explain any complications during pregnancy: \_\_\_\_\_

Did you have a normal delivery with this child? \_\_\_\_yes \_\_\_\_no

If no, please explain: \_\_\_\_\_

typical      spontaneous      induced      Cesarean      breech      unusually long labor

Were there any problems or complications immediately following birth or during the first two weeks of your infant's life? (feeding, seizures, sleeping, swallowing, hospitalizations, etc.):

What was your child's birth weight? \_\_\_\_\_

#### Check if any of the following problems occurred after the child's birth.

- Trouble breathing
- Cord around the neck
- Fever
- Hemorrhage (bleeding) in head
- Large ventricles (hydrocephalus)
- Cyanosis (turned blue)
- Need for ventilation/oxygen
- Jaundice
- Poor feeding
- Vomiting
- Floppy
- Incubator care
- Infection

Other

## V. Medical History

Name of child's Pediatrician/Doctor \_\_\_\_\_

Phone: \_\_\_\_\_

Address \_\_\_\_\_

List any past or current health problems your child has : \_\_\_\_\_

Does your child have allergies (including food)? \_\_\_\_\_yes \_\_\_\_\_no

If yes, please elaborate: \_\_\_\_\_

Is your child currently on medication? \_\_\_\_\_yes \_\_\_\_\_no

If yes, please explain: \_\_\_\_\_

Do you have any concerns about your child's eyesight? \_\_\_\_\_yes \_\_\_\_\_no

If yes, please explain: \_\_\_\_\_

Does your child have a history of feeding problems? \_\_\_\_\_yes \_\_\_\_\_no

If yes, circle all that apply.

choking  difficulty biting  overstuffing mouth

poor nursing  difficulty chewing  difficulty swallowing

Does your child have a history of trouble sleeping through the night? \_\_\_\_\_yes \_\_\_\_\_no

## VI. Hearing

Yes No

\_\_\_\_ Do you feel your child hears well?

\_\_\_\_ Has your child ever had an ear infection? If so, which ear? \_\_\_\_\_

Last occurrence \_\_\_\_\_ First occurrence \_\_\_\_\_ Frequency \_\_\_\_\_

\_\_\_\_ Does he/she presently have or is the past had draining ears?

\_\_\_\_ Does he/she wear hearing aids? If Yes: Make and model \_\_\_\_\_

\_\_\_\_ When did he/she receive the hearing aids? \_\_\_\_\_

\_\_\_\_ Has your child ever had a hearing test? If yes, when? \_\_\_\_\_

Results? \_\_\_\_\_

Does your child appear to attend to your face when listening? \_\_\_\_\_yes \_\_\_\_\_no

Does your child appear to become distracted easily when listening? \_\_\_\_\_yes \_\_\_\_\_no

Does your child appear to be particularly uncomfortable in noise? \_\_\_\_\_yes \_\_\_\_\_no

## VII. Development

Was your child breast-fed?  Yes  No

Duration? \_\_\_\_\_

Describe the circumstances around stopping: Describe the weaning:

\_\_\_\_ Was your child bottle-fed?  Yes  No Duration? \_\_\_\_\_

\_\_\_\_ Describe the circumstances around stopping:

Please check any of the following that described your child as an infant:

- Fussy  Easy to soothe  Difficult to soothe  Startled easily  Sleeping problems  
 Feeding problems  Cried excessively  Colic  Reflux  Failure to thrive  RSV  
 Other

What are your child's sleeping arrangements?

- room alone  with sibling  with parents  with others

Does your child sleep in:  crib  bed  
 Does he/she sleep through the night?  Yes  No  
 If not, how many times does he/she awaken at night? \_\_\_\_\_  
 For how long? \_\_\_\_\_  
 What helps him/her get back to sleep? \_\_\_\_\_

Did/does your child have a special object (blanket, teddy bear, etc.)?  Yes  No  
 If yes, please describe \_\_\_\_\_

If yes, until what age? \_\_\_\_\_  
 Does he/she have any self-soothing behavior?  Yes  No  
 If yes, does he/she:  suck fingers/thumb  use pacifier  other, please describe  
 Does your child exhibit any behaviors that you consider 'odd' or  
 "unusual"? \_\_\_\_\_

How many hours of TV, phone, Ipad, and/or video does your child watch each day? \_\_\_\_\_  
 What are his/her favorites? \_\_\_\_\_

In your opinion, is your child typical for his/her age in:

Self Help Skills

Eating yes\_\_\_\_no\_\_\_\_  
 Toileting yes\_\_\_\_no\_\_\_\_  
 Dressing yes\_\_\_\_no\_\_\_\_

Social Skills

playing with peers yes\_\_\_\_no\_\_\_\_  
 general social interactions yes\_\_\_\_no\_\_\_\_

Please explain any areas checked as "no" \_\_\_\_\_

For toileting, what kind of help and/or what words or gestures will your child be using? \_\_\_\_\_

In your opinion, is your child typical for his/her age in:

Walking yes\_\_\_\_no\_\_\_\_ coloring yes\_\_\_\_no\_\_\_\_  
 Running yes\_\_\_\_no\_\_\_\_ cutting yes\_\_\_\_no\_\_\_\_  
 Jumping yes\_\_\_\_no\_\_\_\_ building with blocks yes\_\_\_\_no\_\_\_\_  
 Going up stairs yes\_\_\_\_no\_\_\_\_  
 Throwing/catching a ball yes\_\_\_\_no\_\_\_\_

Please explain any areas checked as "no": \_\_\_\_\_

Would you describe your child's coordination as: \_\_\_\_\_good \_\_\_\_\_fair \_\_\_\_\_poor?

At what age did your child attain these developmental milestones?

sitting \_\_\_\_\_ walking \_\_\_\_\_

crawling (Please also indicate if there was minimal time spent in the crawling phase)

\_\_\_\_\_ toilet training \_\_\_\_\_

Is your child a messy or picky eater? \_\_\_\_yes \_\_\_\_no

Please list favorite foods: \_\_\_\_\_

Please list food sensitivities: \_\_\_\_\_

What does your child drink from? \_\_\_\_\_Sippy cup \_\_\_\_\_open cup \_\_\_\_\_uses a straw  
 other \_\_\_\_\_

Does your child dislike having substances on his/her hands such as glue or dirt? \_\_\_\_yes \_\_\_\_no

Is your child oversensitive to being touched/dislikes being touched? \_\_\_\_yes \_\_\_\_no

If yes, please describe \_\_\_\_\_

Check all that apply regarding your child, if any.

- dislikes washing his/her face or hair       does not demonstrate caution  
 dislikes haircuts       puts things in his/her mouth besides food  
 spends too little time or too much time brushing his/her teeth       chews on his/her clothes

### VIII. Communication Skills and Cognition

What does your child use the most? \_\_\_\_\_ complete sentences    \_\_\_\_\_ phrases  
 \_\_\_\_\_ one or two words      \_\_\_\_\_ sounds      \_\_\_\_\_ gestures  
 \_\_\_\_\_ physically takes adult to item      \_\_\_\_\_ augmentative communication system

At what age did you child say his/her first word? \_\_\_\_\_

What were the child's first few words? \_\_\_\_\_

Approximately how many words did your child have at... 18 months? \_\_\_\_\_ 24 months? \_\_\_\_\_

At what age did your child say his/her first sentence? \_\_\_\_\_

Give some examples of first sentences: \_\_\_\_\_

Give an example of typical sentences the child currently uses: \_\_\_\_\_

Did speech-language learning ever seem to stop for a period? \_\_\_\_\_

Estimate the percentage of time that your child is understood by:

\_\_\_\_\_ parents      \_\_\_\_\_ other adults      \_\_\_\_\_ brothers and sisters  
 \_\_\_\_\_ friends

Please indicate your child's level of understanding of other's by checking those that apply:

\_\_\_\_\_ understands gestures    \_\_\_\_\_ does not understand spoken words    \_\_\_\_\_ understands single words  
 \_\_\_\_\_ understands simple sentences    \_\_\_\_\_ understands 2 and 3 part commands    \_\_\_\_\_ understands conversation

How does your child understand and use language? Please circle all that apply

- Cries
- whines
- grunts
- Gestures
- Babbles or uses jargon
- Single words
- Putting words together
- Uses 3 to 5 word sentences
- Is difficult to understand
- Follows oral directions
- Can point to objects and pictures named

Does your child typically display any of the following behaviors? (Check all that apply.)

- reduced or lack of interaction with others       difficulty staying on task  
 tantrums       difficulty finishing tasks       passive in interactions  
 sensitive       very active       angry/acting out behavior  
 underactive       frustrated       inattentive  
 shy       refuses to perform tasks

## IX. Sensory Development

Is your child overly sensitive to sensory experiences (e.g., sounds in restaurants, textures, bright lights, smells)?

If so, please explain:

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Does your child take longer to react or not react to sensory experiences (e.g., appears to be in his/her own world, does not respond to his/her name when called)? If so, please describe:

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Does your child seem to actively search or seek out sensory experiences (e.g., constant desire for pushing, pulling, and hanging off things; constantly on the move; seems unable to stop talking; touching people to the point of irritating others)? If so, please describe:

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Does your child have a difficult time distinguishing sensory experiences? (e.g., trouble distinguishing objects in pockets, trouble recognizing objects by their shape, trouble differentiating smells). If so, please describe:

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Does your child seem clumsy (trips/falls frequently) when executing movement, performing unfamiliar movements or completing tasks with multiple steps? If so, please describe:

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Does your child have poor balance during motor activities (e.g., biking, karate, and gymnastics)? If so, please describe:

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Does your child have difficulty sustaining adequate posture at a desk/table (slumps, leans on arm, head too close to work, props head on hands)? If so, please explain:

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## X. Day Care and School Experiences

Does your child attend: \_\_\_\_\_ daycare \_\_\_\_\_ preschool \_\_\_\_\_ other?

Name of daycare or school \_\_\_\_\_

When is he/she in the daycare or preschool program?

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How does your child relate to children in their own age group? \_\_\_\_\_

Other programs your child has attended: \_\_\_\_\_

Does the teacher describe your child with any of the following comments (please check):

Cannot follow directions  Cannot sit still  Seems to be daydreaming

Learns best using multi-sensory approach  Learns best auditorily  Learns best visually

Picks on other children  Is aggressive  Is sneaky Has a difficult time expressing his/her thoughts

Doesn't seem to comprehend what's said  Cannot complete tasks

## XI. CURRENT CONCERNS:

Please check below if you have any concerns about your child in these areas:

Short attention span  Impulsivity  Low frustration tolerance  Oppositional behavior

Aggression  Difficulties with transition  Attention seeking  Hyperactivity

Noncompliance  Social isolation  Lying  Distractibility

Avoidance  Anxiety  Low self-esteem

Awareness of differences  Difficulties separating  Self-stimming

Please list any additional concerns about your

Child: \_\_\_\_\_

When did these problems begin? \_\_\_\_\_

## XII. Other

How would you describe your child?      Reserved?    Confident?    Assertive?      \_\_\_\_\_

How does your child react when he/she is upset or sad? \_\_\_\_\_

What is the best way to comfort him/her? \_\_\_\_\_

How does your child deal with frustration? \_\_\_\_\_

What strategies do you employ? \_\_\_\_\_

How does your child deal with separation? \_\_\_\_\_

List a few of your child's favorite activities: \_\_\_\_\_

Does your child have any pets? (Real or favorite stuffed animal ) \_\_\_\_\_

What other concerns do you have about your child? \_\_\_\_\_

What do you consider to be your child's greatest strengths? \_\_\_\_\_

What do you hope to gain from this evaluation and participation from the program?

\_\_\_\_\_

What do you hope your child will gain from the program?

\_\_\_\_\_ Language stimulation      \_\_\_\_\_ learn more English      \_\_\_\_\_ socializing with peers

\_\_\_\_\_ a general preschool experience      \_\_\_\_\_ to correct speech & language problem

other \_\_\_\_\_

*All information will be held in strict confidence and not released to any person(s) without explicit authorization nor shared with any unauthorized person.*



The Speech and Language Center  
**Authorization for Emergency Medical Attention**

Child's name (print): \_\_\_\_\_ Date of birth: \_\_\_\_\_

Mother's cell #: \_\_\_\_\_

Father's cell #: \_\_\_\_\_

Mother's work #: \_\_\_\_\_

Father's work #: \_\_\_\_\_

Mother's home #: \_\_\_\_\_

Father's home #: \_\_\_\_\_

In the event that we cannot be reached to make arrangements for emergency medical attention, we authorize The Speech and Language Center to take my child to the location listed below, or to the nearest hospital, and we give our consent for any and all necessary treatment:

Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

In case of emergency treatment, please inform the medical staff that our child has the following allergies and takes the following medication(s) on a daily basis (include dosage):

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Please list two (2) people who we may contact in the event of an emergency:

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**THIS FORM MUST BE KEPT UPDATED AT ALL TIMES**

The Speech and Language Center  
**Consent for Treatment**

Client: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

I, \_\_\_\_\_, hereby give consent for the above named child and/or myself to receive services at The Speech and Language Center. This consent is given until I give notice that these services are no longer requested or until The Speech and Language Center professionals notify me these services will no longer be provided. I certify that I have legal responsibility for this child and am authorized to seek and consent treatment for him/her. I understand that all information provided to The Speech and Language Center professionals is confidential and will generally be released to others only with my written consent. I understand that The Speech and Language Center professionals are required to disclose confidential information without my consent in certain circumstances which includes, but is not limited to, 1) if it is determined there is a probability of imminent physical injury by my child to himself/herself or other(s), or if there is a probability of immediate mental or emotional injury to my child 2) if the disclosure is required or authorized by law, legal proceedings, or court order 3) to qualified individuals, corporations, or governmental agencies involved in paying or collecting fees for mental or emotional health services for my child 4) to other professionals and personnel, under the direction of The Speech and Language Center professionals providing services to my child, who participate in the diagnosis, evaluation, or treatment of my child 5) a judicial or administrative proceeding brought against The Speech and Language Center professionals by myself or my child 6) in the event it is believed my child is the victim of physical abuse, sexual abuse, or neglect, or if my child divulges information about the physical abuse, sexual abuse, or neglect of a child, elder, or disabled person.

The professionals rendering services through The Speech and Language Center are dedicated to using established and empirically supported psychological, behavioral, and educational evaluation and intervention procedures to optimize the social, emotional, and cognitive development of each child. In the event a child presents as an immediate danger to himself/herself, others, or property, the least restrictive intervention shall be utilized to provide safety for the child, others, or property. While verbal mediation will be the primary intervention utilized, at times physical contact may be required to provide safety for the child, others, or property.

My signature on this document indicates I have read the above information and have a clear understanding of the procedures, policies, and therapeutic interventions described. I have been given the opportunity to have my questions answered regarding the above-described information. I understand that I have the right to withdraw treatment for my child at any time.

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Publicity and Photo Release

From time to time, we may take pictures and/or video images of The Speech and Language Preschool Center programs and the people we support. These images may then be used for specific internal and external purposes, including marketing, fundraising, and publicity, including Facebook. Personal identification will not be released with any photo and/or videos. However, these images may be used only with the consent of the individual begin photographed or videotaped.

Please sign and ( ) either statement #1 or #2 below to indicate your preference in this matter.

1. ( ) I give my permission for pictures and video images to be taken of

\_\_\_\_\_  
Child's Name (please print).

2. ( ) I choose not to have any pictures or video images taken of my child.

\_\_\_\_\_  
Child's Name (please print)

( ) I have read the above statement of consent and understand it fully. I do hereby give consent as indicated in the release. It may be revoked by me in writing at any time.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please read each policy and initial. Thanks!**

### **Authorize Pick Up Policy**

Our normal procedure is to release the child only to his/her parents, or someone else the parents designate on the Authorized Pick up and Emergency Contact Form. If someone other than the parent is to pick up the child, please notify us ahead of time. A verbal notice is fine on that day, if this person is on the list of people who are authorized to pick up your child. If the person is NOT on that list, we **MUST** have written permission to release your child. Please inform emergency contacts, or people designated to pick up your child, that if we do not know them then we will need to ask for identification. This is not meant to offend them. This is simply a measure taken for the child's protection.

Initials \_\_\_\_\_

### **Tuition**

Tuition is based on enrollment (a reserved space), not on attendance. To maintain a reserved space, fees must be paid during the absence of a child due to illness, holidays, vacation, or for any other reason. If a child does not attend the family/caregiver is responsible for that months session rates. If the child does not attend, and the child receives third party funding, the funding may not be accessible. In that event, the family/caregiver is responsible for that months session rates.

Payment is expected every Monday/Tuesday, prior to the session beginning. In the event of a returned check, there will be a \$25 fee.

Initials \_\_\_\_\_

### **Withdrawing Policy**

On occasion, it may be necessary for a child to withdraw from The Speech and Language Center. In this event, **parents must notify the director prior to the month of withdraw.** If withdraw occurs once the month of services begins, the family/caregivers will be responsible for payment of that months services, whether or not the child is in attendance. In the event that payment is not made prior to withdrawing, parents will be notified by certified letter.

Initials \_\_\_\_\_

### **Sick Policy**

We will do everything we can to keep a healthy environment for your children. We ask for you to help us and the other families by complying with a few health guidelines. Please advise us whenever a member of your family has an illness, so that I can be alert to the possibility of symptoms developing in your child or the preschool class.

Your child should not come to The Preschool if they have any of these symptoms:

- A fever of 100 or higher currently or within the last 24 hours
- An unidentified rash, any open sores or weeping wounds
- A harsh cough or large amounts of yellow or green nasal discharge
- Lethargic behavior (moms usually know when the child isn't feeling well)
- Diarrhea or loose stools currently or within the last 24 hours
- Vomiting currently or within the last 24 hours
- Head lice, pinworms, pinkeye, ringworm, impetigo, etc.

We will not administer any medication (OTC or prescribed) to your children. We are sorry if this presents a scheduling issue for your child and are happy to have you come to The Preschool to treat them. We also would ask that you not leave any medications in the classroom with your child or in your child's bag.

Initials \_\_\_\_\_

### **Closings due to Weather**

We make every effort to remain open during inclement weather. Our goal is to make sound decisions based on the safety of families and staff. We DO NOT follow any school districts closings decisions. We will notify each family via phone call or text and notification will be posted on our Facebook page as soon as a decision is made regarding the severity of the weather and road conditions. If we are closed due to inclement weather, you will not be charged for that day. We will do our best with scheduling to make it up at a later time.

Initials \_\_\_\_\_

### **Late Pick-up Policy**

We understand that at times situations may arise that impact the ability to pick up your child in a timely fashion (**10 minutes or more after session ends**). Session times are firm. After each session all Specialized Therapist have additional clients appointments to report to. If your child is late for pick up on two separate occasions a late pick up fee will be applied of **\$25.00 per occurrence** thereafter. This fee will cover the cost of staff.

Initials \_\_\_\_\_

### **Child Pick-up Authorization**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

Additional persons who may pick up my child:

1. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

2. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

Note: Any person unfamiliar to us will be required to show proof of identification.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## HIPAA- QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Departments of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. The Speech and Language Center and Preschool Telephone: (573) 514-3525 Address: 4812 Santana Cir. E-mail: [admin@thespeechlanguagepreschool.com](mailto:admin@thespeechlanguagepreschool.com) I acknowledge that I reviewed and agree to the Notice of Privacy Practices.

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

Childs Name \_\_\_\_\_

If you would like a copy of the HIPAA print out, please contact The Speech and Language Center at 573-514-3525

## **What is CoMO SEPTA?**

A Special Education Parent Teacher Association (SEPTA) provides families and educators with an organizational structure, resources and the opportunity to be a collective voice for their special needs children. CoMO SEPTA has the benefit of reaching district-wide to bring together individuals with similar needs. We will be able to discuss issues, share resources, support our students and more.

## **Who is welcome to join?**

Anyone with an interest in the welfare of students who access special education services in the Columbia, MO area is encouraged to join. Any type or level of disability, any age from preschool through high school, any classroom setting. Maybe you're a special education teacher, a therapist, or a general education teacher who has some students with special needs. Maybe you're a parent who's still looking into special education services, maybe you're a homeschooler who uses some special services through the public schools. Maybe you have a student who's in a typical classroom with some supports, maybe you have a student who is in a self-contained classroom. We'd love to have you join us.

## **What makes a SEPTA different from a typical PTA?**

The SEPTA will be focusing on parent support and education. We will have speakers on topics of interest, topics that are a problem issue, education about transitions between the various levels, and more. In addition, we are hoping to offer parent to parent support for IEP/504 or other school meetings. It is always helpful to talk with someone that has been through it and offer advice, or just an additional person to be at the table to take notes. We would also like to have a time after the meetings for just general talk/support time, if anyone needs it that evening.

## **If I join CoMO SEPTA, should I still join my school's PTA?**

Absolutely. Getting involved in both the school PTA and CoMO SEPTA is a great way to encourage inclusion and helps keep the lines of communication open to all parent groups. Families can then be a part of all school activities, ensure the inclusion of their children and still have their own format for the special supports and opportunities that they may see. Individual PTAs provide parent involvement opportunities and cover school-specific issues that CoMO SEPTA will not cover as a community-wide parent organization.

## **What is the membership fee?**

The membership fee is \$10 per person, with a discounted fee of \$5 for an additional family member. Furthermore, you can provide a scholarship to cover the membership fee of someone else. We don't want to turn anyone away because of financial hardship, so let us know if you need assistance.

## **Who are our officers?**

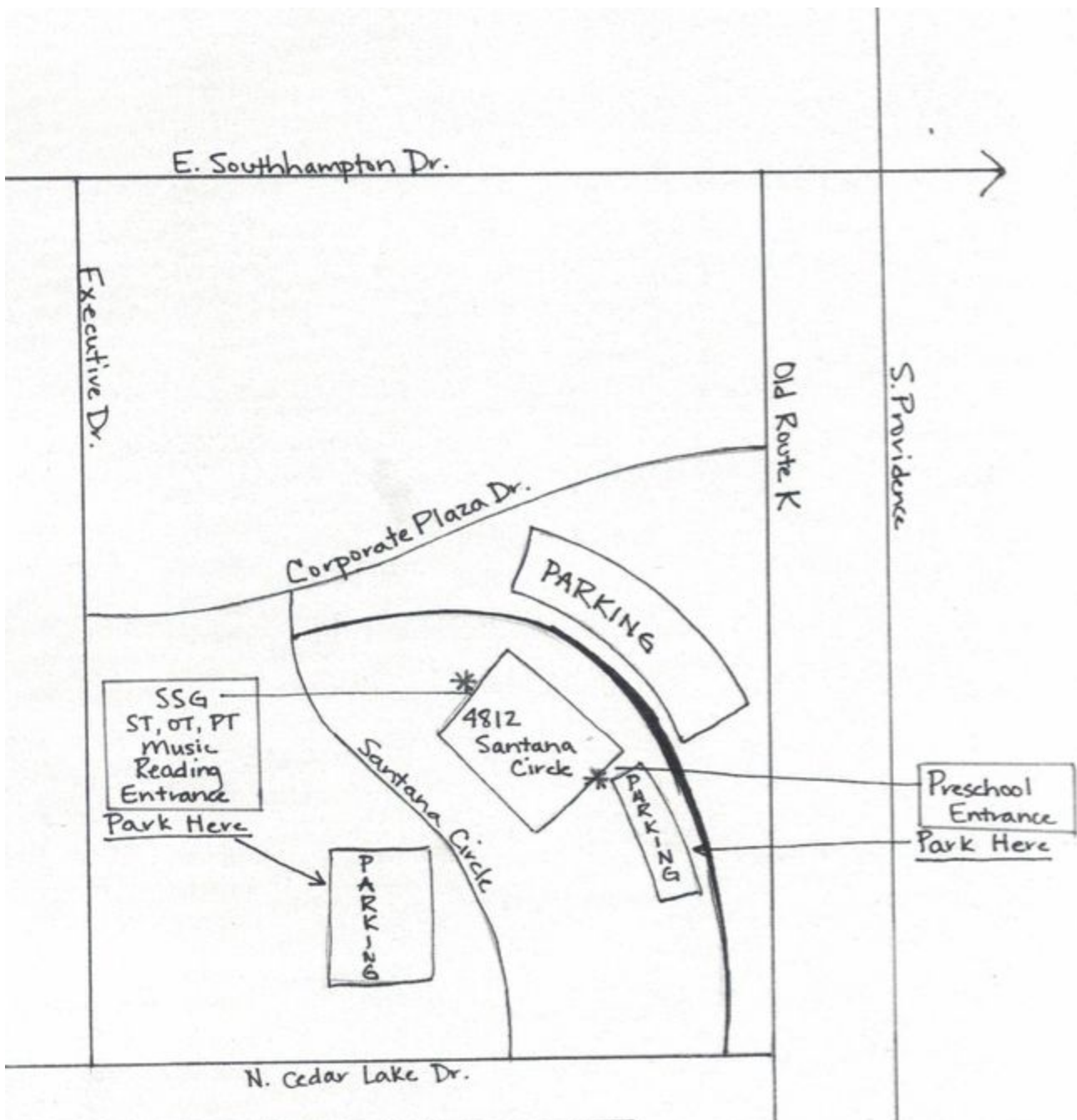
Michelle Ribaldo, President

Amie VanMorlan, Vice President

Tara Arnett, Treasurer

Kaitlyn Houston, Secretary

Contact us at [comosepta@gmail.com](mailto:comosepta@gmail.com), fill out our [contact form](#), or let us know [on Facebook](#).



SSG  
ST, OT, PT  
Music  
Reading  
Entrance  
Park Here

Preschool  
Entrance  
Park Here

SSG - Social Skills Group Evenings  
ST - Speech Language Therapy  
OT - Occupational Therapy  
PT - Physical Therapy



