Vision, Speech, Hearing and Developmental Screenings

The Special Senses and Communication Disorders Act mandates that all schools show proof that vision and hearing tests have been performed on children who are 4 years old, children who are in grades K, 1, 3, 5, 7, and 9, or children who are first time entrants to the school. Although this law does not mandate speech screenings, it is encouraged that any child 3 years or older receive a speech-language screening or children at any age who may have concerns in speech and language development receive a speech-language screening. The earlier a possible problem is identified, the earlier a child can receive help and possibly reduce the chance for later academic problems.

To keep in compliance with this law, we are offering vision, speech, and hearing screenings at our school on **October 21st and 22nd**. The cost of the screening is $25.00 per child. A copy of the results will be provided to both you and the school.

Please fill out the form below and return it to your child's teacher by **October 21st, 22nd** or complete the form on our website, www.capitaltherapygroupaustin.com and submit your credit card payment. If your child meets the criteria requiring tests, as listed above, and you prefer to have this done elsewhere, you must provide the school with a copy of the results of the vision and hearing tests. The test must have been performed within one year from the school enrollment date. The school is required to have this record on file to complete the necessary forms for the State Dept of Health.

Thank you for your cooperation!

_____ _____ _____ _____
Student's Name Age Date of Birth Phone #

_____ _____ M T W Th F
Teacher's Name Room Name / Number Days Attending

Please check one of the following:

_____My child has permission to participate in the vision, hearing, and speech screening. I have enclosed cash, check*, credit card (via website), or money order for $25.00.

_____I am choosing not to participate in the screenings and will provide the school with a copy of the results of my child's vision and hearing tests by _____.

Do you have any concerns about your child's vision, speech, hearing or development?

_____
Parent Signature

*Please make checks payable to ***Capital Therapy Group***