

Adams Wells Special Services  
925 N. Main Street  
Bluffton, IN 46714  
260-824-5880

North Adams Community Schools  
Adams Central Community Schools  
South Adams Schools

Northern Wells Community Schools  
MSD Bluffton-Harrison  
Southern Wells Community Schools

Speech Screening Permission

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

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

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

Telephone: \_\_\_\_\_

Parents: \_\_\_\_\_

School: \_\_\_\_\_

Teacher: \_\_\_\_\_

Grade: \_\_\_\_\_

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I, legal guardian of \_\_\_\_\_, give my permission for Adams Wells Special Services Cooperative to complete a speech/language screening. I understand that should the results indicate that no further evaluation is needed, I have the right to request such evaluation.

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

\_\_\_\_\_  
Date

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\_\_\_\_\_  
Student Name

Dear Parents:

A speech and language screening was recently conducted on your child at \_\_\_\_\_.

Results indicate:

\_\_\_\_\_ Your child passed the speech and language screening.

\_\_\_\_\_ Your child passed the speech and language screening; however, some sound errors were noted. These errors are typical for your child's age.

\_\_\_\_\_ Results of the screening indicated that further evaluation is needed. In order to pursue further evaluation, complete the attached form and return it to school with your child.

If you have any questions or concerns, do not hesitate to contact me.

Thank you,

\_\_\_\_\_  
Speech Language Pathologist  
Adams Wells Special Services Cooperative

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date Sent