Center for Speech, Language and Learning, Inc.
6230 Tenth Street, Suite 220
Oakdale, MN 55128
651-739-2300
Fax: 651-739-2302

Child: ____

Place of
Observation/Testing/Therapy:____

I, ____, give permission for
Parent Name

____, of Center for Speech, Language and
Name of Therapist

Learning, Inc. to observe, test, or treat my child for speech and/or occupational therapy purposes, in this environment. I also give permission for therapists that work with my child at this facility, to collaborate and share information with direct care teachers and/or daycare providers, related to the above stated purposes.

____   _______________________
Parent   Date