WORD OF MOUTH
Clinical Associates

CONTACT INFORMATION

Date: _____

Full Name of Child: _____ Age: ____ Date of Birth: _____ Gender: _____

School: _____ School Phone: _____ Grade: _____

Teacher(s):_____

Teacher(s) e-mail:_____

Allergies: _____

Pediatrician: _____

Parent #1: _____ Phone: (home) _____ (cell)_____

Employer: _____ Phone: (work) _____

Home Address: _____ City: _____ Zip : _____

Email Address: _____

Parent #2: _____ Phone: (home) _____ (cell)_____

Employer: _____ Phone: (work) _____

Home Address: _____ City: _____ Zip : _____

Email Address _____

Do you mind if your child's session is briefly discussed with you in our lobby (with the therapist bringing you back to a therapy room for more sensitive discussions)?

Check: Yes, I do mind _____ No, I do not mind _____

May Word of Mouth Speech Clinical Associates and/or Sky High publish or display a picture of your child for our website content, social media content, marketing materials, or use for educational presentations?

Check: Yes _____ No _____