Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AM / PM

 (Circle One)

Currently Sego Lily Elementary is offering the interventions outlined below. Interventions consist of 15-20 minutes of additional instruction once or twice weekly with a Speech-Language Pathologist. These sessions will take place in your student’s regular school time during a time that will not disrupt your child’s learning in the classroom. The interventions will typically last about 12-16 weeks. At the end of the Interventions, Speech services may end without further contact and the student may be returned to the regular education curriculum without additional support unless further recommendations are made by the SLP.

Please review and sign the attached sheet and return as quickly as possible. Thank you,

Sue Stagg, MS, CCC-SLP

lstagg@alpinedistrict.org - email

801-610-8717 ext. 135 - school #

385-455-9844 - text/cell #

**Your student has been recommended for the following:**

* **Group Time** with Ms. Stagg and possibly a small group of other students to work on age appropriate sounds and/or language concepts.
* **English Language Learning (ELL)** is a set of activities designed to help students become proficient in English as a second language.
* **Fluency Group Time** with Ms. Stagg and possibly a small group of other students to work on fluency/stuttering.
* **Returning to Regular Education Curriculum**, no longer receiving Speech services.

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* Yes, my child has permission to participate in the above group(s) as indicated.
* No, my child does not have permission to participate in the above group(s) as indicated.

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

* I prefer to be contacted by email. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I prefer to be contacted by phone. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I prefer to be contacted by text messages. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Speech Language Therapy Requirements:**

**Speech Therapy services will be provided to those students who participate and adhere to the following requirements:**

* **I understand my student is required to do daily practice.**
* I understand a parent/guardian must sign homework logs to verify that practice occurred.
* I understand that my child will turn in completed homework sheets for rewards. These rewards are intended as an incentive for the student to practice and use newly learned skills in the home environment.

**Rewards** consist of a variety of items such as pencils, erasers, rings, stickers, etc. There may also be wrapped candy, cookies, crackers, cakes, etc. Students who are not allowed to have food will have these other rewards available to choose from.

* **I GIVE MY PERMISSION** for my child to have food/treats.
* **I DO NOT GIVE MY PERMISSION** for my child to have food/treats.
* He/She **DOES** have food allergies. Please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* He/She **DOES NOT** have food allergies.
* I understand that my student may be released from Speech Therapy services if the above stated requirements are not met.

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

Notes/comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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