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Bloom Therapy
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# Consent Form

(Please use **CAPITAL LETTERS**)

Child's Name: _____ DOB: ____/____/_____

Mother's Name: _____ Father's Name: _____

Contact Numbers: _____/ _____

Email Address: _____

School/Nursery: _____ Grade/Class: _____

Teacher: _____ Email Address:_____

*I,* _____ *give consent to Bloom Therapy Speech Center to conduct a Speech & Language and/or Occupational Therapy screening for my child.*

| Speech and Language Therapy | Occupational Therapy |
|---|---|
| ☐ speech is unclear and/or some sounds not pronounced correctly<br>☐ difficulty understanding information and/or following instructions<br>☐ difficulty using words, making sentences and sharing information<br>☐ difficulty communicating wants and needs<br>☐ stuttering/stammering<br>☐ challenges with friendships and social interactions | ☐ difficulty with fine motor skills (e.g. using scissors, holding a pencil)<br>☐ difficulty with gross motor skills (e.g. running, jumping, climbing)<br>☐ sensitivity to sensory input (e.g. avoiding certain textures, sounds)<br>☐ difficulty with self-care tasks (e.g. dressing, feeding)<br>☐ difficulty with balance and coordination<br>☐ challenges with planning and organizing tasks<br>☐ challenges in spatial awareness (e.g. following directional instructions, understanding personal space, orientation and copying shapes)<br>☐ challenges with attention and focus |

Additional notes:.....

Parent/Guardian Signature: _____

Date: _____ Witness: _____