Grow Pediatric Therapies

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SCREENING CONSENT FORM

Child's Name: Date of Birth:

Parent/Guardian Name: Phone Number:

Pediatrician: Insurance Provider:

By signing below, I give Grow Pediatric Therapies my consent to screen my child, named above, for physical, occupational, speech-language/communication and other related concerns.

_____

Parent/Guardian Signature Date

BELOW IS FOR OFFICE USE ONLY

Areas of Strength:

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Areas for Further Evaluation:

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Recommendations:

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_____

Additional Notes:

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_____

Provider_____**Date**_____