BELLA VISTA SCHOOL DISTRICT

SPEECH AND LANGUAGE SCREENING

DATE_______________________________________

STUDENT'S NAME____

Please check areas of concern:

_________Articulation of speech sounds

_________Overall intelligibility

_________Fluency (Stuttering)

_________Voice

_________Grammar/Syntax

_________Language Processing

Comments:____

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____

Parents have been notified of this referral? ________Yes _________No

Parent comments:

____

____

(For Speech Pathologist Use)

Date Screened: ____

Impressions:____

Action Taken:____