

Parent Application for Summer 2024 Programs

Please print legibly & return via fax (540.568.5757), email (ScottishRite@jmu.edu), or to the JMU Speech-Language Clinic

Child's First Name: _____

Child's Last Name: _____

Date of Birth: _____

Phone (Home): _____

Gender: M F Other Prefer not to say

Leave a message? Yes No

Parent(s)/Guardian(s): _____

(Work): _____

Address: _____

Leave a message? Yes No

City/State/Zip: _____

(Cell): _____

Email: _____

Leave a message? Yes No

Which number would you prefer we use to contact you? Home Work Cell

Child's Primary Language: ___English ___ Spanish ___ Other (specify): _____

Other language(s) spoken at home: _____

Do you or the child require an interpreter: Yes No

Please respond to each question:

Has your child ever received occupational or physical therapy? YES NO

If you answered yes, please explain:

Does your child have any diagnosis other than speech and language? YES NO

If you answered yes, please explain:

Does your child have any allergies? YES NO

If you answered yes to allergies, please list them here:

Does your child currently use a feeding tube? YES NO

If you answered yes, please list formula type and frequency here:

Does your child currently use a speech generating AAC device? YES NO

If you answered yes, please describe the device here:

For example: LAMP, Touch Chat, Proloquo2Go, etc.

Is your child *consistently* toilet trained? YES NO

Does your child currently attend school or daycare? YES NO

Does your child attend the JMU Young Children's Program? YES NO

Do you have any affiliation with Scottish Rite Freemasonry of Virginia? YES NO

If yes, identify the relationship to your child _____

REMINDER: CHILDREN ENROLLED IN THE SUMMER PROGRAM ARE EXPECTED TO ATTEND ALL SCHEDULED CLINIC DAYS; JMU DOES NOT PROVIDE TRANSPORTATION.

Summer session dates: **Monday-Thursday, June 10th -July 23rd** (no clinic on Fridays)

*No clinic on June 19th or July 4th & 5th

We will be offering different clinic options (see the program letter for more information); please check all of the programs that you are interested in your child being considered for:

___ JMU Young Children’s Program

___ JMU Speech-Language Clinic

___ Morning speech & language group sessions

___ 8:30am – 10:00am

___ 10:30am – 12:00pm

___ Morning feeding group sessions

___ 8:30am – 10:00am

___ 10:30am – 12:00pm

___ Afternoon individual sessions

Parent or Guardian Signature

Date

*Please note that you do not need to submit this application for the Adagio House Summer Day Camp program. Please visit for more information and registration: <https://adagiohouse.org/community-center/summer-day-camp/>

SLP Referral Form

(To be completed by the referring speech-language pathologist)

Child’s Name: _____ Age: _____

Name of SLP: _____

Name of Agency/School: _____

Email Address: _____ Telephone: _____

Please consider the nature of the communication disorder & rate *level of difficulty* in the following areas:

| | No Concern | Mild | Moderate | Severe |
|--|---------------|------|----------|--------|
| Following directions | 0 | 1 | 2 | 3 |
| Following the classroom routine | 0 | 1 | 2 | 3 |
| Answering basic questions (who, what, where, yes/no) | 0 | 1 | 2 | 3 |
| Answering questions about stories/classroom activities | 0 | 1 | 2 | 3 |
| Maintaining the topic during brief conversation | 0 | 1 | 2 | 3 |
| Maintaining age-appropriate attention | 0 | 1 | 2 | 3 |
| Expressing ideas using age-appropriate grammar | 0 | 1 | 2 | 3 |
| Asking simple questions (who, what, when, where, why) | 0 | 1 | 2 | 3 |
| Using age-appropriate vocabulary when talking | 0 | 1 | 2 | 3 |
| Using language to communicate with others | 0 | 1 | 2 | 3 |
| Engaging in appropriate play with others | 0 | 1 | 2 | 3 |
| Transitioning from one activity to another | 0 | 1 | 2 | 3 |
| Being understood by an unfamiliar listener | 0 | 1 | 2 | 3 |
| Producing all age-expected phonemes | 0 | 1 | 2 | 3 |

Please provide a summary of child's current level of performance including any assessment information:

Please provide current goals and note progress:

Would this client benefit from a speech-generating AAC device? YES NO

**If yes, please describe trials AAC trials completed thus far.

Are there any behavioral concerns of which we should be aware? YES NO

** If yes, please describe the behavior as well as any successful strategies that you use.

Please list the client's interests:

**** Note: Please attach any supporting documentation (reports, summary letters, current IEP)**