



LANGUAGE ESSENTIALS

Speech and Occupational Therapy

COMMUNICATION & SPECIAL NEEDS SHEET

STUDENT NAME: _____

PARENT/GUARDIAN NAME (1): _____ PARENT/GUARDIAN NAME (2): _____

SPEECH/OT THERAPIST NAME: _____ THERAPIST EMAIL: _____

PARENT PREFERRED COMMUNICATION METHODS:

☐ EMAIL: _____

☐ PHONE: _____

☐ IN-PERSON NOTES/MEETINGS

BEST TIME TO REACH ME: _____

CURRENT SPEECH/OT GOALS: _____

STRATEGIES THAT WORK WELL FOR MY CHILD : _____

ADDITIONAL SUPPORTS NEEDED : _____

ADDITIONAL NOTES: