School District of the City of Erie, PA

Department of Pupil Personnel Services

Office of Child Study

Please identify the following that apply to this student:

**SPEECH ONLY**

**DISMISSAL from Speech services [Date of NOREP** **]**

**Speech with other Exceptionalities**

## PLEASE COMPLETE BOTH PAGES

**Student Name:**

**Speech/Language Therapist:**

**School:**

**Existing Evaluation Data:**

Name of Test Date of Test Score

Please check the student’s areas of deficiency:

Misarticulation of one or more sounds Unintelligible speech

Language (oral expression) Hearing Difficulties

Language (listening comprehension) Stuttering or fluency

Voice quality (hoarse, nasal)

**Please indicate the area(s) being addressed in speech/language therapy and with what interventions:**

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**How is the student progressing towards his/her goals:**

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**How do his/her speech difficulties impact his/her functioning in the regular education curriculum:**      .

Is the current IEP appropriate: If no, please describe and indicate what changes need to be made:      .

Conclusion:

Additional data is needed:

If additional data is needed, please indicate what information is needed and why:

ADDITIONAL INFORMATION PERTAINING TO THE STUDENT:

Date Submitted