TENNESSEE STATE UNIVERSITY
DEPARTMENT OF SPEECH PATHOLOGY & AUDIOLOGY

Intensive Language, Articulation, Fluency, & Diagnostics
Summer L.A.F. Camp 2017

The Department of Speech Pathology and Audiology will provide intensive therapeutic intervention focusing on Language, Articulation, and Fluency (L.A.F) for qualified applicants, ages 5-12. Five year olds must have completed kindergarten. There is no cost. Persons interested should **scroll down** to access the application and submit it along with any prior diagnostic assessment reports, IEPs and other pertinent data, to the following address:

LAF (Speech) Camp
Department of Speech Pathology and Audiology
330 10th Ave. North, Suite N200
Nashville, TN 37203
Applications must be postmarked on or before April 26, 2017.

Scheduled Diagnostics: June 7th through 8th
Full Camp Dates: June 12th through June 29th
Time: Monday through Thursday, 9:00 am – 12:00 pm

Language Camp
Treatment and maintenance of receptive and expressive language

Articulation Camp
Treatment of speech sounds

Fluency Camp
Treatment and maintenance stuttering therapy

Contact Persons:
Danielle Watson 615-963-7092 & Katherine Walsh @ 615-963-7339
Email: **dhayes10@tnstate.edu OR kwalsh1@tnstate.edu**

TSU-17-0091(A)-7c-13655– Tennessee State University does not discriminate on the basis of race, color, national origin, sex, or disability. See our full policy at www.tnstate.edu/nondiscrimination.

TENNESSEE STATE UNIVERSITY

Speech, Language, and Hearing Clinic

PATIENT INTAKE FORM

FILE # _____

PATIENT'S FULL NAME: _____Circle: Adult / Child

FATHER'S NAME: _____MOTHER'S NAME: _____

ADDRESS: _____

_____

TELEPHONE: Home _____Work_____ Cell_____

DATE OF BIRTH: _____ AGE: _____MALE: _____FEMALE: ___

PRIOR SPEECH SERVICES RECEIVED (When) _____ (Where) _____

CLIENT WILL RETURN FOR _____ Summer _____Fall _____Spring Session

PROBLEM DESCRIPTION: _____

_____

REFERRED BY: _____ DATE: ____

********TO BE FILLED OUT BY CLINICAL STAFF*********

INITIAL VISIT IS SCHEDULED FOR: _____ Time: _____AM/PM

SPEECH:

Diagnostic _____ Therapy _____

AUDIOLOGY:

Diagnostic _____ Rehabilitation _____

Clinician: _____Supervisor: _____

Referral Source: _____

TENNESSEE STATE UNIVERSITY
DEPARTMENT OF SPEECH PATHOLOGY AND AUDIOLOGY
330 10th Avenue North, Suite A
Box 131
Nashville, TN 37203-3401

PERSONAL HISTORY-CHILD

Note: Please complete this form and return to the above address.
Include Department of Speech Pathology and Audiology

Date:_____

I. GENERAL INFORMATION

Child's Full Name_____
Current Age_____ Birthdate_____
Sex: M( ) F( )

Address:_____
Street City State Zip Code

Phone#:_____
Mother's full name:_____
Age_____ Education completed:_____
Residence:_____
_____
Daytime Phone #_____
Father's full name:_____
Age_____ Education completed:_____
Residence:_____
_____
Daytime Phone #_____
List all persons living in the home:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Physician_____
Pediatrician_____

I believe my child has difficulty with:

_____ speech (articulation)
_____ language
_____ voice
_____ fluency
_____ hearing
_____ other _____

Describe the problem in detail (Use back of sheet if needed):

_____
_____
_____
_____
_____
_____
_____

What do you think caused the problem? _____
_____
What has been done to correct it?_____
_____
How does the child seem to feel about his/her problem?_____
_____
_____
Does any other family member have a speech or hearing problem?_____
(If yes, state nature of problem and relationship to child)_____
_____
_____
_____

II. EARLY HISTORY

Health of mother during pregnancy_____
Diseases, accidents, drugs, x-ray treatment of mother during pregnancy_____
_____
Exposure to any infectious diseases during pregnancy_____
Which pregnancy was this child?_____ Full term?_____
Length of labor?_____ Was delivery normal?_____
Child's weight and condition at birth_____
Describe any birth problems_____
_____
Was child's development normal for sitting, standing, walking, etc.?_____
Describe any health or feeding problems during early childhood_____
_____

III. LANGUAGE DEVELOPMENT (List ages carefully. This is very important.)

When did child begin to babble or coo?_____
When did child speak first words?_____ Sentences_____
How does the child make his wants known?_____
_____
Was there anything different about the way the child made sounds, noises, words, etc., during the first two years?_____ Explain. (Preferred to point or gesture; started talking and then stopped, etc.)_____
_____
When was the problem first noticed?_____ By whom?_____
Has the child's speech changed recently?_____
What does the child do when his speech is corrected?_____

Does the child repeat your questions instead of answering them?_____

IV. HEARING (Complete if you think your child has a hearing problem)

What makes you think your child has a hearing problem?_____
_____
How old was the child when you realized there was a hearing problem?_____
Does he pick or pull his/her ears?_____
Does your child wear hearing aids?_____
Left Ear_____Right Ear_____Both Ears_____

V. HEALTH HISTORY (Give age and severity of following illnesses your child has had).

Illness	Age	Describe Illness
Measles	_____	_____
Mumps	_____	_____
Chicken Pox	_____	_____
Pneumonia	_____	_____
Allergies	_____	_____
Tonsillitis	_____	_____
Ear Infections	_____	_____
Fainting	_____	_____
Seizures	_____	_____
Diabetes	_____	_____
High Fever	_____	_____
Visual	_____	_____
Asthma	_____	_____
Frequent Colds	_____	_____
Thyroid Trouble	_____	_____
Paralysis	_____	_____
Heart condition	_____	_____
Other	_____	_____

What operations and/or serious accidents has the child had? (include dates)____
_____
_____
What medication, if any, does the child receive?_____
_____

Is the child clumsy?_____Explain_____

SCHOOL
Current School _____ Address_____
_____
Grade_____ Teacher_____
What is the child's attitude toward school?_____
Describe any school difficulties (reading, writing, etc.)_____
_____
_____
Has the child ever had an intelligence test?_____ Explain_____
_____

VI. EMOTIONAL ADJUSTMENT AND PERSONAL CHARACTERISTICS

How would you describe the child's personality?_____
How does the child respond to people?_____
Is the child hard to manage?_____
Does the child sleep and eat well?_____
How is the child punished?_____
Has the child ever experienced a severe shock or fright?_____
If so, explain_____

***Notes:**

1. It is very likely that your child's session/s will be observed by students enrolled in Speech Pathology or Audiology courses.

2. It is our policy to terminate clients who are absent from therapy for 3 consecutive sessions without prior notification from the client to the Clinical Coordinator or Supervisor.

Client/ Family Responsibilities

1. The client must be on time and prepared for camp.
2. If a client is greater than 25 minutes late for camp, that day will be cancelled and considered an absence. Excessive tardiness can result in dismissal from camp.
3. If a client or parent cancels a session due to illness or other conflicts, please contact your primary clinical supervisor before 8:00 a.m., the day of the session, at _____ or the clinic secretary at 963-7072.
4. You have the right to request a meeting with the clinical supervisor or the clinician with the supervisor present. However, we do request that you allow at least 48 hours advance notice.
5. You have the right to review your chart and or your child's chart. However, we request a 48 hour notice.
6. If the client misses 2 consecutive sessions they may be dismissed from camp.
7. We reserve the right to discharge and refer a client to other service providers for valid reasons.
8. You have the right to observe your child but not to disrupt the treatment process.
9. Parents/legal guardian must be in attendance the first day of camp to sign all consent and release forms.
10. The parents/caregiver must sign in each day and sign out each day. No minor child shall be left or dropped off or picked up without signing in/out. No minor child shall be allowed to exit the suite without parental/caregiver supervision.
11. Our clinic is part of a university training program; student clinicians and clinical supervisors are changed based on academic and practicum requirements each semester.

_____ _____

Signature (If under 18 years of age parent/guardian) Date

_____ _____

Student Clinician Clinical Supervisor

PARENT COPY

CONSENT FORM: TESTING/THERAPY/RESEARCH

Patient's Name:_____

1. I do_____do not_____ give my permission for me/my child to receive speech/language/hearing *screening(s)* for the Tennessee State University Speech and Language Clinic.

2. I do_____do not_____give my permission for me/my child to receive speech/language/hearing *evaluation(s)* from tbe Tennessee State University Speech and Language Clinic.

3. I do_____do not_____give my permission for me/my child to receive speech/language/hearing *therapy* from the Tennessee State University Speech and Language Clinic.

4. I do_____do not_____give my permission for the Tennessee State University Speech and Lanugage Clinic to use my/my child's clinical information anonymously for *research* purposes only.

5. I do_____do not_____give my permission for me/my child to be *observed* by Tennessee State University's students.

6. I understand that a complete Diagnostic Evaluation must be completed by Tennessee State University Speech and Language Clinic before therapy service can be initiated.

7. I understand that Speech-Language therapy services will be cancelled in the event of missed appointments without proper notification.

_____

Signature (if under 18 years of age, parent/guardian)

_____

Date

PARENT COPY