Central Mississippi Incorporated
Head Start Program
Health Services Division
Speech and Language Screening

CENTER NAME:______________________

Name		
Age		
Date of Birth		
Mailing Address		
Phone Number		
	PASS	**FAIL**
Speech Results		
Language Results		

PROVIDER'S SIGNATURE: ______________________ DATE:______________________

white: Central Office *Blue: Child's File*

Revised 06/04

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