**EASTERN KENTUCKY UNIVERSITY**

*Serving Kentuckians Since 1906*

College of Education
Department of Special Education
Speech/Language/Hearing Clinic

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# SECURITY POLICY

In an effort to provide safety for all clients under the age of 18 years, the EKU Speech-Language-Hearing Clinic requires the completion of this form. Services will not be provided until the form is submitted. Thank you for your cooperation.

Client Name: _____Parent/Guardian Name: _____

Home Phone: (___) _____ Work Phone: (___)_____ Cell Phone: (___)_____

I, as a parent/guardian of _____, give my permission for the following individuals to pick up my child from the EKU Speech-Language-Hearing Clinic waiting room following any diagnostic and/or therapy session:

1.) _____Name of Individual 2.) _____Name of Individual

_____Relationship to Client _____Relationship to Client

_____Phone Number _____Phone Number

This permission is in effect for _____ (semester and year). I understand that my child must be picked up in the clinic waiting room and will convey this information to individuals listed on this form. I understand that these individuals may be required to show proof of identity. I further understand that my child will *not* be released to anyone, other than myself, or those listed in this form without my written and signed consent. Parent/Guardian or designated other, must remain in the clinic area during the entire time of therapy visit for all children under the age of 16.

| _____ | _____ | _____ |
|---|---|---|
| Printed Name of Parent/Guardian | Signature of Parent/Guardian | Today's Date |

If your child is 16 years of age or older and you wish for them to be released without the accompaniment of a responsible adult, please sign and date the following statement:

_____ has my permission to leave the EKU Speech-Language-Hearing Clinic without accompaniment of a responsible adult.

| _____ | _____ | _____ |
|---|---|---|
| Printed Name of Parent/Guardian | Signature of Parent/Guardian | Today's Date |

Kentucky UNBRIDLED SPIRIT