ASU SPEECH AND HEARING CENTER
P.O. BOX 910 STATE UNIVERSITY, AR 72467-0910
PH. (870) 972-3301 FAX (870) 972-3788

INFORMED CONSENT

The Arkansas State University Speech and Hearing Center has two purposes; to train student speech-language pathologists, and to provide the best possible assessment and treatment services to clients and families enrolled in its programs. Because we train students, it is important for them to be able to observe assessment and treatment sessions by direct observations, by listening to audiotapes, and/or by watching videotapes of those sessions. These observations and tapes may be used as part of the assessment or treatment process, as teaching demonstrations to students and other professionals, or to collect and report data for research analysis.

CLIENT'S NAME: _____ FILE #:_____

INITIALS AND DATED NEEDED ON EACH LINE

CONSENT IS REQUESTED FOR:	CONSENT GRANTED	CONSENT NOT GRANTED	DATE
ASSESSMENT			
1. Assessment of speech, language, and/or hearing disorders	_____	_____	_____
2. Direct observation of assessment by students and their instructors	_____	_____	_____
3. Audiotaping/Videotaping for assessment purposes	_____	_____	_____
4. Audiotaping/Videotaping for indirect observation of assessment	_____	_____	_____
5. Audiotaping/Videotaping for workshop/ professional demonstration of assessment	_____	_____	_____
6. Use of assessment data for statistical/ research analysis	_____	_____	_____
TREATMENT			
7. Treatment of speech, language, and/or hearing disorders	_____	_____	_____
8. Direct observation of treatment by students and their instructors	_____	_____	_____
9. Audiotaping/Videotaping for treatment purposes	_____	_____	_____
10. Audiotaping/Videotaping for indirect observation of treatment	_____	_____	_____
11. Audiotaping/Videotaping for workshop/ professional demonstration of treatment	_____	_____	_____
12. Use of treatment data for statistical/ research analysis	_____	_____	_____

Signature of person granting consent:_____
Name of person granting consent (please print):_____
Relationship to client: _____self _____parent/guardian/designee
Student Clinician Signature:_____ Date:_____