Eau Claire Area School District
Speech/Language Department
500 Main Street
Eau Claire, WI 54701

Early Childhood Speech Sound
Request for Assistance Process

Speech Sound Assistance Plan

Student Name:		Grade:
Student Birthdate:	Age:	School/Childcare:
Parent/Guardian:		Teacher/Childcare Provider:
Address:		Telephone:
Home Phone #:		Email:
Alternate Phone #:		
Email:		Date of Meeting:

Members attending:

Student's current performance

- Potential concerns:

- Sound Errors noted:

- Observations of Child:

Recommendation(s):

Cues that worked with your child:

Sound Target Schedule

Week 1: _____ Week 2: _____ Week 3: _____ Week 4: _____

☐ We ask that parents/caregivers actively and enthusiastically implement home programming activities and suggestions

Follow Up Date: _____

Contact Person/Phone Number: _____

Follow Up Action:

Distribution: Parent / Early Childhood Teacher / S/L Pathologist