



PROFESSIONAL CONTACT FORM

Parents: please complete this form and return to Chatham Academy

Child's Name _____

I give Chatham Academy permission to contact the following organizations and individuals for release of transcripts, teacher reports, evaluations, and any standardized testing.

Current School _____

Address City State Zip Telephone

Classroom Teacher _____

Address City State Zip Telephone

Pediatrician _____

Address City State Zip Telephone

Psychiatrist _____

Address City State Zip Telephone

Psychologist _____

Address City State Zip Telephone

Neurologist _____

Address City State Zip Telephone

Speech and Language Therapist _____

Address City State Zip Telephone

Occupational/Physical Therapist _____

Address City State Zip Telephone

Educational Tutor _____

Address City State Zip Telephone

Additional services and individuals not listed above _____

Address City State Zip Telephone

Parent's Signature _____

Date _____