



NAME \_\_\_\_\_

BIRTHDAY \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_



- I HAVE DYSARTHRIA.
  - I HAVE DIFFICULTY COMMUNICATING.
  - SPEAK SLOWLY AND CLEARLY.
  - PLEASE GIVE ME TIME TO TALK.
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