Sick Policy

If you or your child are feeling ill, we kindly request you cancel your visit. ***Holly Springs Feeding & Speech*** will be happy to reschedule your visit once you or your child is feeling better. Please understand that you will be coming into a therapy office where other infants, children and other individuals may be ill or have a vaccine preventable disease.

While you are the best judge of you and your child's health, and we trust you will not bring a sick person to the clinic, if in the opinion of the therapist that you or your child is sick, we will request to end the session at the discretion of the therapist.

While a 24-hour cancellation is ideal per cancellation policy, if you or your child begins to show symptoms within 24 hours, we ask that you notify your therapist as soon as possible (noting that repercussions of cancellation policy are not applicable for sudden illness).

The following criteria should be considered in determining of canceling your appointment:

- a fever of 100 degrees or more
- inflammation of the eyes (excessive redness, glassy or discharge)
- vomiting
- more than one incidence of diarrhea or loose stool which is not contained within clothing
- communicable disease as defined by the Department of Health Services/Center for Disease Control
- unknown rash
- excessive nasal discharge, especially if yellow or greenish, since this indicates infection

If you have a suspected exposure to COVID you must have negative COVID test or assurance that the person you were exposed to is also negative before returning to the clinic.

After you or your child has been ill, we ask that you or your child do not return to the clinic at least 24 hours after no longer experiencing these symptoms.

These guidelines are to ensure the health and safety of you or your child, as well as staff and the infants, children and adults who enter our clinic.

Thank you for cooperation and please contact the owner with any concerns.

By signing this form, you are stating that you have read and agreed to the above.

Patient Name (printed): ____

Patient Date of Birth (DOB): ____

____ ___________________________

Parent/Guardian Signature Date

Thank you for understanding -

Jill Odle, MS CCC-SLP
Speech Language Pathologist & Feeding Specialist
OWNER: Holly Springs Feeding and Speech