1. ***Parent/Carer Request for***

***Externally Funded Service Providers***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| https://lh3.googleusercontent.com/wbH7yKsk71Hi7O-ECkemhKia4JDz-EpVZOSgEwr_Pn6qeN_Nuq09yTbDrcEoGsp9Xg_KtAnP8Lg7dnAi6G5P0V22ZVNhvdrp7nvy87pct5BWyWwVVXav_kRPubqNPN0wLERAljC0   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | *Student Details*  *Completed by parent or carer* | Student Name |  | DOB | |  | | **Class** |  | | | | | **Parent/Carer Name** |  | | | | | I hereby provide written consent to the agreed service delivery arrangement and for the sharing of information related to the provider’s services to my child between the provider and the school. I understand I am responsible for notifying the school if I terminate the provider’s services and to notify the provider if my child will not be at school on a day scheduled for service delivery at the school. | | | **Parent/Carer Signature:**  **Date : / /** | | |
| https://lh3.googleusercontent.com/wbH7yKsk71Hi7O-ECkemhKia4JDz-EpVZOSgEwr_Pn6qeN_Nuq09yTbDrcEoGsp9Xg_KtAnP8Lg7dnAi6G5P0V22ZVNhvdrp7nvy87pct5BWyWwVVXav_kRPubqNPN0wLERAljC0   |  |  |  |  | | --- | --- | --- | --- | | *External Provider Details*  *Completed by parent or carer in consultation with therapist* | Therapist Name |  | | | **Organisation** |  | | | **Dept # If already issued** |  | | | **Email Contact** |  | | | **Phone Contact** |  | | | **Role**  **Registration Details** | **🞎** Speech Pathologist **🞎** Physio. **🞎** OT **🞎** Other (advise):\_\_\_\_\_\_\_\_\_\_ | | | **Managers Name Contact Details** |  | | | **Timeframe/Sessions**  Maximum length of support is 40min session | ***School Term***  🞎 Term 1 🞎 Term 2 🞎 Term 3 🞎 Term 4  ***Type*** 🞎 Observation only (one off) 🞎 Series of sessions | | | | ***Location of delivery***  🞎Classroom 🞎Playground 🞎Other: | | *Time and day to be determined in consultation with teacher/therapist. Parents to be notified and kept updated of any changes.* ***It is the parents responsibility to notify the therapist if the child is absent from school.*** | | Goal/s of Intervention:  🞏 This request supports the following student PLP Goal : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 This request supports another goal that has been discussed with the parent and classroom teacher.  Teacher to Initial  *Please write down the goal for the student e.g. At the conclusion of these sessions the student will* | | | | | The therapist has confirmed they have;  🞎 I have provided therapy at Fisher Road School post October 2017(school will verify existing documentation on file)  🞎 I have not provided therapy at Fisher Road School before (documentation below required) | | | | Documentation required by therapist prior to request being considered. *It is a responsibility of the parent/carer and therapist to complete and provide all necessary documentation to the school before the approval of this request.* | | | | 🞎 provide a completed Declaration for Child Related Work - Specified Volunteers and Child-Related Contractors (first time at DoE School).  🞎 show the school some form of photo identification with date of birth details  🞎 Provide evidence of Currency for; - Workers Compensation, or, if the provider is an individual or sole trader performing the work  themselves, evidence of personal insurance cover in the event they have an injury   * Professional Indemnity (no less that $2 million) * Public Liability (no less than $20 million)   🞎 provide certificate showing proof of completion of DoE Child Protection Awareness Training including  mandatory reporter procedures <http://cpat.learnbook.com.au/> or a suitable alternative training program developed by the provider for its staff, within the last year  🞎 provide evidence of relevant health care training (first aid, CPR, ASCIA) where a school determines that the  Provider should undertake specific health care training. Mandatory for all providers working with a student who has an ASCIA Allergy/Anaphylaxis plan. | | | |  | | |   ***This request is to be submitted to the school office with all documentation for consideration at the next learning and Support Team Meeting*** |