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

***Externally Funded Service Providers***

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| https://lh3.googleusercontent.com/wbH7yKsk71Hi7O-ECkemhKia4JDz-EpVZOSgEwr_Pn6qeN_Nuq09yTbDrcEoGsp9Xg_KtAnP8Lg7dnAi6G5P0V22ZVNhvdrp7nvy87pct5BWyWwVVXav_kRPubqNPN0wLERAljC0

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| *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 : / /** |

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| https://lh3.googleusercontent.com/wbH7yKsk71Hi7O-ECkemhKia4JDz-EpVZOSgEwr_Pn6qeN_Nuq09yTbDrcEoGsp9Xg_KtAnP8Lg7dnAi6G5P0V22ZVNhvdrp7nvy87pct5BWyWwVVXav_kRPubqNPN0wLERAljC0

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| *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 includingmandatory 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.  |
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***This request is to be submitted to the school office with all documentation for consideration at the next learning and Support Team Meeting*** |