Request to School for Third Party Clinical Access

PARENT / GUARDIAN REQUEST FORM

Parent initiated service provider request for students with disability.

This form is to be completed by parents / guardians to request access for external service providers, such as therapy services, for their child at school, during school hours. Please note the completion of this form does not constitute an agreement to allow for therapy to be undertaken in the school. Entry and access to the school are always at the discretion of the Principal.

This form should also be completed by parents requesting a one-time classroom observation by external service providers for assessment purposes.

The school will consider your request in line with the:

- student's educational and wellbeing needs;
- school's ability to provide appropriate facilities for therapy; and
- ability of the student to access the service outside of school hours.

You will be contacted within seven working days on the outcome of this request.

The delivery of therapy services in the school is appropriate when there is a clear link between the therapy and the enhancement of the student's educational experience and outcomes. Priority will be given to therapy that clearly aligns with the student's individualised learning goals. If the school believes that this application does not meet this criterion the request will be denied. Entry and access to the school are always at the discretion of the Principal.

If therapy or a request to undertake classroom observations is approved, further paperwork or screening documentation will be required to be completed or provided, as per CEWA guidelines and procedures.

PLEASE COMPLETE ALL SECTIONS AS REQUIRED

Student Details

Student Name:	**Date of Birth:**
Teacher:	**Year:**

Parent / Guardian Details

Parent / Guardian Name:	
Email:	**Contact Number:**

Service / Therapy Request Details:

Information about the support your child needs access to at school, during school hours (please complete one form per service provider).

Does this request relate to classroom observations or ongoing support / therapy?

Is the classroom observation a school request? ◯ **YES** ◯ **NO** ◯ **N/A**

Name of provider:

Role:

Are they NDIS registered? ◯ **YES** ◯ **NO** ◯ **UNSURE**

What type of support / therapy are you requesting to provide?

- ☐ Speech Therapy
- ☐ Occupational Therapy
- ☐ Psychology
- ☐ Behaviour Therapist
- ☐ Physiotherapy
- ☐ Medical
- ☐ Other: .....
- ☐ Classroom observation for assessment purposes

Does the support / therapy relate to any of the student's current IEP goals? ◯ **YES** ◯ **NO**

If yes, please explain:

Outline why the support / therapy needs to be provided at school, during school hours?

How often will support / therapy be provided? ☐ **ONCE** ☐ **WEEKLY** ☐ **FORTNIGHTLY** ☐ **MONTHLY**

Preferred day: **Preferred time:**

Duration of support / therapy:

SCHOOL TO COMPLETE

Date request received: **Date request acknowledged:**

Request approved: ◯ **YES** ◯ **NO** **Date parent / guardian advised of outcome:**

Principal or Delegate Name:

Signature: **Date:**

Comments: