Externally Funded Service Providers Delivering Health, Disability and Wellbeing Services

Request from Parent

Student:

Service provision requested: …… (eg physio, speech).

Name of service provider: …… Phone contact of service:…….

Email of Service: ……..

Therapists name:……..

Expected outcome or goal of the service:

The service is;

☐ Intervention ☐ Observation

Frequency of service	Session Time	Duration of service
☐ Weekly	☐ 30 minutes	☐ Term 1
☐ Fortnightly	☐ 45 minutes	☐ Term 2
☐ Monthly	☐ 60 minutes	☐ Term 3
☐ Other	☐ Other	☐ Term 4

Please indicate how the service goals will link to your child's educational personalised learning and support goals.

☐ I understand that a decision will be made regarding the provision of therapy services during school hours for my child by the school leadership team.

☐ I understand that if there is no suitable times or learning space available in my child's class the service cannot commence, rather, the request will be placed 'on hold' and reviewed at the end of the semester.

☐ I have provided relevant documents relating to the above services such as therapists reports.

Parent/Carer Name (print)…….. Date……...

Parent/Carer Signature…….

Please return this to the school so services during school time can be considered.

Contact the school is you wish to discuss this request.