



PARENTS / CARERS REQUEST FOR THE DELIVERY OF THERAPY SERVICES AS PER NDIS PLAN DURING SCHOOL HOURS 2020

Before completing this form, please read William Rose school guidelines and procedures document on *Working with externally funded service providers delivering health, disability and wellbeing services to students* which can be located on the school website. This form is to be completed in consultation with the class teacher, in advance of any therapy service provision commencing at our school. One form may be used for multiple service provision requests.

Student name		Class teacher	
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Therapy service requested	Name of the organisation delivering the service
Speech	
Occupational	
Physiotherapy	
Behavioural	
Other	

Please outline the link between the therapy service goal and your child's PCLP goal:

Eg: (Please tick)		
<input type="checkbox"/> Communication	<input type="checkbox"/> Vision/Hearing	<input type="checkbox"/> Orientation and mobility
<input type="checkbox"/> Accessing the community (using public transport)	<input type="checkbox"/> Other (please specify) _____	

If student has more than one service please place therapy initial (e.g. S - speech, O - occupational) near timeframes

Frequency of service delivery	Session time	Duration of service delivery
<input type="checkbox"/> Weekly	<input type="checkbox"/> 30 minutes	<input type="checkbox"/> Term 1
<input type="checkbox"/> Fortnightly	<input type="checkbox"/> 60 minutes	<input type="checkbox"/> Term 2
<input type="checkbox"/> Monthly	<input type="checkbox"/> Other :	<input type="checkbox"/> Term 3
<input type="checkbox"/> Once or twice a term	<input type="checkbox"/>	<input type="checkbox"/> Term 4
<input type="checkbox"/> One off consultation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>

I/We understand that:
<input type="checkbox"/> that school will be notified if the services are terminated
<input type="checkbox"/> that service provider will be notified if my child will not be at school on a day scheduled for service delivery.
<input type="checkbox"/> The service provider will need to undertake a school based induction before commencing services
<input type="checkbox"/> School can cancel the provider's visit at any time due to unforeseeable reasons.

I _____ hereby give consent to the school to allow visit/s by the above mentioned service providers at the mentioned/negotiated times for my child. I acknowledge that I have read and understood WRS guidelines and procedures document on *Working with externally funded service providers delivering health, disability and wellbeing services to students*.

Parent/Carer name _____ Parent/Carer sign _____ Date _____

Staff name _____ Staff sign _____ Date _____