



**CONSENT FOR WESTERN SYDNEY UNIVERSITY PEDIATRIC STUDENTS  
(FOR PROFESSIONAL EXPERIENCE ONLY)  
EXCHANGE OF INFORMATION 2020**

The school collaborates with Western Sydney University (WSU) Paediatric students to assist them with their research and projects. They will be liaising with the School Counsellor to access students' reports for their educational, psychological and medical information and may contact you to gain further information.

I \_\_\_\_\_ (parent/carer name)

give my permission for the Western Sydney University Paediatric students to:

- gain access to student reports from the school counsellor      Yes ☐      No ☐
- contact parents via phone      Yes ☐      No ☐

\_\_\_\_\_ who attends William Rose School.

(child's name)

I understand that I have the right to stop regarding the above permission at any time if I wish by notifying the school in writing.

Signed \_\_\_\_\_

Parent/Carer Name \_\_\_\_\_ (print name)

Date \_\_\_\_\_