PARENT REQUEST FOR ONSITE THERAPY

A request for therapists to conduct onsite therapy in the classroom is to be completed by parents. Please email the completed form to: samson.ps@education.wa.edu.au

<table>
<tr><td colspan="5">Therapist Details</td></tr>
<tr><td>Name</td><td colspan="4"></td></tr>
<tr><td>Position</td><td colspan="4"></td></tr>
<tr><td>Organisation</td><td colspan="4"></td></tr>
<tr><td>Organisation Address</td><td colspan="4"></td></tr>
<tr><td>Email Address</td><td colspan="4"></td></tr>
<tr><td>Phone Contacts</td><td colspan="2">(w)</td><td colspan="2">(m)</td></tr>
<tr><td colspan="5">Please email the following documentation to: samson.ps@education.wa.edu.au
❑ Therapy Plan ❑ Working with Children Card ❑ Certificate of Insurance / Public Liability</td></tr>
<tr><td colspan="5">Students Details</td></tr>
<tr><td>Student Name</td><td colspan="4"></td></tr>
<tr><td>Class Teacher</td><td colspan="2"></td><td>Year</td><td></td></tr>
<tr><td colspan="5">Service Provision Requested</td></tr>
<tr><td colspan="5">❑ Speech Therapy ❑ Occupational Therapy ❑ Physiotherapy
❑ Other______________________________</td></tr>
<tr><td colspan="5">Expected outcome of the Therapy Sessions.</td></tr>
<tr><td colspan="5"></td></tr>
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Will there be a clear link between the therapy providers' therapy session and IEP Goals?	❑ Yes ❑ No

Frequency of Service	Session Length (Mins)	Duration of Service
❑ Weekly ❑ Fortnightly ❑ Monthly		❑ Term 1 ❑ Term 2 ❑ Term 3 ❑ Term 4
Preferred day of the Week		
Preferred time of the day		

Consent and Authority (parents and therapists please initial next to condition)
❑ I understand that a decision will be made regarding the provision onsite therapy during school hours after a review of its appropriateness with the class teacher and the student's parents or carers and administration. ❑ I understand that should no suitable times be available in the student's class the service cannot commence. The request will be placed "on hold" and reviewed at the end of each semester. ❑ I authorise Samson Primary School and the above-mentioned provider to share relevant information regarding my child. ❑ I understand that the use of video recording and photography is strictly prohibited. ❑ I understand the importance of privacy and confidentially of all the students on school grounds and will not collect data on or report information regarding other students. All curriculum is the intellectual property of the Department of Education. Reproduction and distribution is prohibited without written consent.

Parent Signature		Date: / / 2020
Therapists Signature		Date: / / 2020

To be completed by Samson Primary School		
Status of Service Provision Request		
❑ Approved	❑ Declined	❑ On Hold

Have the following been provided to the school?	❑ Therapy Plan ❑ WWC Check Evidence ❑ Certificate of Insurance / Public Liability	
Approved by Administrator		Date: / / 2020
Approved by Principal		Date: / / 2020
Time and Date of First Session		