**Request for Externally Funded Service Providers**

**Cardiff Public School**

**Work in Harmony**

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| **Student Details** | **Student Name** | Enter Student Name |
| **Class** | Click or tap here to enter text. | **D.O.B.** | Click or tap to enter a date. |
| **Parent/Carer Name** | Click or tap here to enter text. |
| I hereby provide written consent to the agreed service delivery arrangement and for the sharing of information related to the provider’s services to my child between the provider and the school. I understand I am responsible for notifying the school if I terminate the provider’s services and to notify the provider if my child will not be at school on a day scheduled for service delivery at the school. | **Parent/Carer Signature:****Date: DD / MM / YYYY** |

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| **External Provider Details** | **Therapist Name** | Click or tap here to enter text. |
| **Organisation** | Click or tap here to enter text. |
| **Dept #** if already issued | Click or tap here to enter text. |
| **Email Contact** | Click or tap here to enter text. |
| **Phone Contact** | Click or tap here to enter text. |
| **Role** | [ ]  **Speech Path.** [ ]  **Physio.** [ ]  **OT** [ ]  **Social Worker** [ ]  **Other: Enter** |
| **Manager’s Name & Contact** | Click or tap here to enter text. |
| **Timeframe/Sessions****(max. 40min/session)** | **School Term:** [ ]  **Term 1** [ ]  **Term 2** [ ]  **Term 3** [ ]  **Term 4****Type:** [ ]  **Observation ONLY (one-off)** [ ]  **Series of sessions** |
| **Preferred Day:** [ ]  **Mon** [ ]  **Tues** [ ]  **Wed** [ ]  **Thu** [ ]  **Fri****Preferred Time: 1) Time 2) Time 3) Time** **Frequency:** [ ]  **Weekly** [ ]  **Fortnightly** [ ]  **Monthly** [ ]  **Other:** |
| **Location:** [ ]  **Classroom** [ ]  **Withdrawal Space** [ ]  **Playground** [ ]  **Other:** |
|  | **Time and day to be finalised in consultation with teacher/therapist. It is the parents’ responsibility to notify the therapist if the child is absent from school or if other event is occurring that will impact a visit.** |
|  | **Reason for in-school request** | Click or tap here to enter text. |

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| **Goal/s of Intervention:** Teacher Initial & Date:**□** This request supports the following student PLSP Goal: Click or tap here to enter text.**□** This request supports another goal that has been discussed with the parent and classroom teacher. ***Goal e.g. At the conclusion of these sessions the student will:***Click or tap here to enter text. |   |

**Documentation required by therapist prior to request being considered. It is a responsibility of the parent/carer and therapist to complete and provide all necessary documentation to the school before the approval of this request.**

* provide Declaration for Child Related Work - Specified Volunteers and Child-Related Contractors (first visit @ DoE School).
* provide Photo Identification with date of birth details

Provide Evidence of Currency for:

* Workers Compensation, or, if the provider is an individual or sole trader performing the work themselves, evidence of personal insurance cover in the event they have an injury
* Professional Indemnity (no less than $2 million)
* Public Liability (no less than $20 million)
* Evidence of completion of DoE Child Protection Training including mandatory reporter procedures http://cpat.learnbook.com.au/ or a suitable alternative training program developed by the provider for its staff, within the last year
* Evidence of relevant health care training (first aid, CPR, ASCIA) where a school determines that the Provider should undertake specific health care training. Mandatory for all providers working with a student who has an ASCIA Allergy/Anaphylaxis plan.

**This request is to be submitted to the school office with all documentation for consideration at the next Learning and Support Team Meeting**