James Fallon High School

Together We Succeed

Parent request for service provision to be conducted during school hours

A written request by parents/carers is required in advance of any service provision commencing in school.

Student information

Full name: _____

Class teacher: _____

Parent/Carer contact information

Name(s): _____

Phone number/s: _____

Email address: _____

Preferred method of contact: (tick preference) Phone: ☐ Email ☐

Purpose of therapy

Type of therapy requested (For example: speech pathology, occupational therapy, physiotherapy, psychology, hydrotherapy or other):

_____

Please briefly explain how the therapy will help your child participate in learning at school:
(For example: supporting communication with teachers and other students, improving movement or coordination for writing, using tools, or joining in sport, or helping manage emotions and behaviour to stay calm and ready to learn)

_____

_____

_____

Frequency of service (weekly, fortnightly, monthly, once or twice per term): _____

Session time (30 minutes, 60 minutes, other): _____

Duration of service: _____

☐ I understand that the decision will be made regarding the provision of therapy services during school hours after a meeting with the school.

☐ I understand that the decision regarding the provision of therapy services during school hours is made at the discretion of the principal, who must consider a number of important factors.

Parent signature: _____ **Date:** _____

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