**Specialist Disability Support in Schools (SDSS) Program**

**School Request for Support Form**

**SECTION A**

**(If this request is for more than one eligible student, only one section A is required)**

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| ***Please Note –*** *It is a requirement of your Service Agreement to obtain a signed School Request for Support Form for each student which* ***must*** *be renewed* ***each school year****.*  *A renewal form for the next school year signed by the School Principal (or approved delegate) and renewed Parent/Guardian consent with the original approved School Request for Support Form attached can be used to meet this requirement. Any other renewal arrangements must first be approved by the Department of Education to ensure these mandatory requriements are met.*  ***Form Option*** *– Approved organisations may either utilise this Form in its entirety* ***or*** *incorporate all provisions contained within this Form into their own document for Schools to request services under the SDSS Program.* |

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| **Service Type** | | | |
| 🞎 | School Support Services | 🞎 | Resource Centre Services |
| 🞎 | Specialised Equipment |  |  |

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| **Service Request** | |
| School Name: |  |
| School Street Address: |  |
|  |  |
|  |  |
| School Postal Address: |  |
|  |  |
| School Email Address: |  |
| School Phone Number: |  |
|  |  |
| Name of person making request: |  |
| Position of person making request: |  |
| School Contact’s Phone Number: |  |
| School Contact’s Email Address: |  |
| Convenient time to contact: |  |
| Classroom Teacher’s Name: |  |
| Class: |  |

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| Has the school contacted their Regional Office to check if there are any supports and/or school based therapies available from the education sector? |  | 🞎 | Yes | 🞎 | No |

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| **School Consent** |

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| **Please indicate your consent by ticking the box beside the statements below:** | | |
| 🞎 | I give permission for (Name of Organisation), to provide services at our school, or as negotiated and agreed to by the above organisation and school. | |
| 🞎 | I understand that the SDSS services are to be provided in collaboration with the education professionals in the student’s educational team. | |
| 🞎 | I understand that (Name of Organisation) will provide advice and support for the development and implementation of the student’s Individualised Education Plan. | |
| Principal’s (or delegate’s) signature: | |  |
| Print Name: | |  |
| Date: | |  |

**SECTION B**

**(If this is for multiple eligible students, one Section B must be completed for each eligible student)**

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| **Student Details** | | | | | |
| First Name & Last Name: |  | | | | |
| Preferred Name: |  | | | | |
| Date of Birth: |  | | | | |
| School Year Level: |  | | | | |
| Postal Address: |  | | | | |
|  |  | | | | |
| Parent/Guardian Name (1): |  | | | | |
| Parent/Guardian Email Address: |  | | | | |
| Parent/Guardian Phone Number: |  | | | | |
| Parent/Guardian Name (2): |  | | | | |
| Parent/Guardian Email Address: |  | | | | |
| Parent/Guardian Phone Number: |  | | | | |
| Does this student identify as: | | | | | |
| Aboriginal | | 🞎 | Yes | 🞎 | No |
| Torres Strait Islander | | 🞎 | Yes | 🞎 | No |
| Other Cultural Background (please specify below) | | 🞎 | Yes | 🞎 | No |
| Nationality/Cultural Background | |  | | | |

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| * Does the student access specialist education services at the school? | | | | | | |
| 🞎 | * Special Education Support | 🞎 | AVT | 🞎 | * Therapy Services | |
| 🞎 | * Special Education School | 🞎 | Teacher Aide Support |  |  | |
| 🞎 | * Other (Please provide further details): | | | | | |
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| What other Organisations or Services are involved in supporting the Student? | | | | | |

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| Student’s verified impairment areas: | |
| 🞎 | Autism Spectrum Disorder |
| 🞎 | Hearing Impairment |
| 🞎 | Intellectual Disability |
| 🞎 | Physical Impairment |
| 🞎 | Speech – Language Impairment |
| 🞎 | Vision Impairment |
| 🞎 | Social Emotional Disorder (Non-State Schools only) |
| Further Details: | |
| Please describe key concerns regarding the student’s access to and participation in the curriculum: | |
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| **Evidence of Eligibility** | | | | | | | |
| Student has been verified? | 🞎 | Yes | 🞎 | No | 🞎 | Awaiting verification |
| Primary verification category: |  | | | | | | |
| Verified by: | 🞎 | State School | 🞎 | Catholic Education | 🞎 | Independent Schools Queensland |
| Verification date: |  | | | | | | |
| Other verification category: |  | | | | | | |
| Other verification date: |  | | | | | | |
| Other documentation: |  | | | | | | |
| Documents – please attach:  🞎 Current Individualised Education Plan  🞎 Relevant school policies and procedures including student safety and mandatory reporting requirements | | | | | | | |

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| **Parent/Guardian Consent** | |
| Student’s Name: |  |
| Date of Birth : |  |
| Parent/Guardian Name: |  |
| Parent/Guardian Address: |  |
|  |  |
| Telephone: |  |
| Email: |  |

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| **Please indicate your consent by ticking the box beside the statements below:** | | | | | | |
| 🞎 | I give consent for my child to receive therapy services from (Name of Organisation) as requested by the school. I understand that these services may include Speech Therapy, Occupational Therapy, Physiotherapy, Teacher/Educator, Teacher Aide/s. | | | | | |
| 🞎 | I give consent for Therapists/Educators to discuss my child’s learning needs with therapist from other support agencies (DET, Q Health, private therapists). | | | | | |
| 🞎 | I give consent for                                                                                               (Name of School), to release information regarding my child to the (Name of Organisation). I understand that this may include reports from Occupational Therapy, Physiotherapy, Speech Language, Educator, IEP/ILP or School. | | | | | |
| 🞎 | I understand that information will be used by therapists to support my child’s education and to complete the Support Data associated with funding requirements. | | | | | |
| 🞎 | I understand that assessment and/or follow up services will be provided as required and appropriate, and that this may involve discussions with other agencies about my child. | | | | | |
| 🞎 | I give permission for a meeting regarding my child to proceed if I am unable to attend. | | | | | |
|  | There are court orders / custody arrangements which apply to my child: | | | | | |
|  |  | 🞎 | No | 🞎 | Yes - copies of relevant document/s must be provided prior to commencement of services |  |

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| Parent/Guardian Name: |  | |
| Parent/Guardian Signature: |  | |
| Date: |  | |
| **Privacy Collection Notice:** The personal information gathered by (Name of Organisation) on this form is for the purpose of delivering services to improve access to and participation in curriculum and educational outcomes and will not be used for any other purpose or given to any other party unless you have consented or we are authorised by law to do so. | |