Kilparrin Teaching and Assessment
School and Services
Statewide Support Service

1 C Duncan Avenue
Park Holme SA 5043
Tel: (08) 8277 5999
Fax: (08) 8277 5800
Web: www.kilparrin.sa.edu.au
E: dl.1372.info@schools.sa.edu.au

Request / Consent for Support - Confidential

For children / students who have hearing and/or vision impairment and additional disabilities

SECTION 1: CHILD / STUDENT DETAILS

Surname:_____ Given Name:_____ Date of Birth:_____

Parent(s)/Caregiver(s):_____ Gender: M / F

Address:_____ Telephone No.:_____(work)

_____ Post Code:_____ Telephone No.:_____(home)

Parent email:_____

Site: _____ Site contact: _____

Sensory Impairment(s): Vision ☐ Hearing ☐

Additional disability(s) *(eg: Autism, Cerebral Palsy, Down Syndrome)* (Please note this does not include speech and language disorders)_____

_____

Note: For this referral to proceed a recent copy (within 2 years) of a medical/specialist report relating to vision and / or hearing impairment is required.

SECTION 2: INFORMATION FROM PARENT / CAREGIVER

Child's Ophthalmologist: _____ Report attached? Yes / No

Ophthalmologist Address: _____

Child's Audiologist: _____ Report attached? Yes / No

Audiologist Address: _____

Other **Service Providers** (eg CanDo4Kids, Guide Dogs SA/NT, Novita) **AND role**: (eg Physiotherapist, Speech Pathologist, Occupational Therapist):_____

_____

PARENT / CAREGIVER CONSENT

1. I consent to my child having support from Kilparrin Statewide Support Service. Yes ☐ No ☐
2. I give permission for medical details relevant to my child to be released to Kilparrin Yes ☐ No ☐
3. I consent to the exchange of relevant information between Kilparrin and medical professionals / service providers listed above, and / or between Kilparrin and the site Yes ☐ No ☐
4. I consent to the exchange of relevant information between Kilparrin and DCP (if applicable) N/A ☐ Yes ☐ No ☐

Preferred method of contact: ☐ Phone ☐ Email

Signed: _____ (Parent/Caregiver) Date: _____