



# Parent/Guardian Consent Form

I, (parent/guardian)   
 give permission for (name of service)   
 to share information regarding my child with ACT Inclusion Support Agency to assist with his/her  
 inclusion into the program.

Signed  Date

Child's Information					
Name					
Date of Birth					
Days child attends (please circle)	Mon	Tue	Wed	Thu	Fri

I give my permission for the ACT Inclusion Support Agency to liaise with, and share information about my child with the following agencies/professionals already supporting the care and education of my child.

Signed  Date

Agency/Professional	Key Contact	Phone
Behaviour Support Team		
Clinical Psychologist		
Therapy ACT (please specify OT, speech, physio etc)		
Early Intervention Unit/Special School		
Private Therapist (please specify)		
Social Worker/Case Manager		
Pediatrician		
Other		

