**Specialist Teacher Advisory Service**

**Parent/Carer permission form**

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| **Reason for referral:** | **Hearing Impairment** |  | **Visual Impairment** |  | **IT Support** |  |

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| **Pupil Name** |  | **D.O.B.** |  |
| **Family name*****If different*** |  | **Gender** |  |
| **Name of Parent****/Carer** |  |
| **Contact details** | **Address:** | **Postcode:** |
| **Email:** | **Phone number:** |
| **Name of Setting/****School** |  | **National Curriculum Year** |
| **Address** |  | **Phone number:** |
| **Contact Person** |  |
| **Email address** |  |

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| **Is English an additional language?** |  | **If yes, other languages** **spoken at home** |  |

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| **Diagnosis (if known) /Areas of concern** |
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| **Other Professionals Involved***e.g. Ophthalmologist, Audiology, Implant Centre, Paediatrician, Portage, Health Visitor, Social Worker, Family Engagement worker, G.P., Occupational Therapist, Physiotherapist, Speech and Language Therapist* |
| **Professional** | **Name** | **Contact details** |
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| **What do you hope the outcome of the intervention to be? (IT Support only)** |
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| **Parent/Carer Comment- Is there anything else you would like us to know?** |
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| I understand, that by completing this form, a member of the Specialist Advisory Team will advise me on ways to support my child, following the completion of any relevant paperwork. RH **(Parent to tick)**  |  |
| I understand, that by completing this form, a member of the Specialist Advisory Team will advise my child’s School/Setting on ways to support my child and complete any relevant paperwork. RH **(Parent to tick)** |  |
| I understand, that by completing this form, the Specialist Advisory Team may need to discuss my child’s needs with relevant professionals in services for children (e.g. Speech and Language Therapist, Hospital consultants, Early Years Advisory Teachers, Health Visitors etc.) RH **(Parent to tick)**  |  |
| I am happy to receive relevant communications from the STA team, including newsletters. I understand that I can opt out at any time. **(Parent to tick)**  |  |

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Parent’s Name:…………………………………………….Signature: ………………………………………..Date:…………………