

PARENT PERMISSION REFERRAL FORM

to be completed by parent or guardian

Student Name	Parent/Guardian Name	
<input type="text"/>	<input type="text"/>	
Date of Birth	Phone	
<input type="text"/>	<input type="text"/>	
Medicare Number	Email	
<input type="text"/>	<input type="text"/>	
Reference No.	Expiry Date	Address
<input type="text"/>	<input type="text"/>	<input type="text"/>
School Name	City/Suburb	Post Code
<input type="text"/>	<input type="text"/>	<input type="text"/>

Parent/Guardian Consent:

- I/We give permission for our child to be seen by an OzChild counsellor for up to 10 individual counselling sessions per calendar year. In addition to this my child may be seen for up to 10 group counselling sessions per calendar year.
- I/We give permission for these counselling sessions to bulk billed to Medicare.
- I/We give permission for the release of relevant information to those who have responsibility for the care of my/our child at school where this would enable improved support and wellbeing of my/our child at school. This permission also allows for any previous reports and assessment results by other professionals to be released to the OzChild counsellor.
- I/We agree to information about my/our child's mental health being shared between the OzChild counsellor and my/our child's GP to assist in the management of their health care.
- When a person or persons are at risk of being harmed or harming themselves, the OzChild counsellor is obligated to notify the appropriate authorities.
- I have read and understood *Shine Assist Privacy Statement (SA03)*.

Parent/Guardian Signature

Parent/Guardian Name (please print)

Date

Parent/Guardian Signature

Parent/Guardian Name (please print)

Date

OzChild Education Services

Level 3, 150 Albert Road, South Melbourne VIC 3205
t: (03) 9695 2200 f: (03) 9696 0507 e: EducationServices@ozchild.org.au
www.ozchild.org.au

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Student Name:

Name of Parent/Carer Completing this Form:

1. Please list family members (include stepparents, stepsiblings, grandparents, etc) who live in the home and their ages.

Family member	Name	Age

2. Are there any family members (particularly parents or siblings) who live elsewhere? Please list their names, ages, and reasons for moving out.

Family member	Name	Age	Reason for moving out

Has there been a divorce in the family? Yes No
If so, when?

Please describe the custody arrangements:

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Please describe the concerns you have regarding your child.

Describe any treatment already tried, e.g. therapy or medication:

Please provide details of involvement of other professionals, e.g. social worker, speech pathologist etc.

Describe your child's relationship with their peers:

Child's interests/hobbies:

Is there any other information you think the OzChild counsellor should know?

Please return the completed 3 pages to the OzChild counsellor.

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