**Specialist Teacher Advisory Service**

**Parent/Carer permission form**

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

|  |  |  |  |
| --- | --- | --- | --- |
| **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** |  | | |

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

|  |  |  |
| --- | --- | --- |
| **Diagnosis (if known) /Areas of concern** | | |
|  | | |
| **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** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **What do you hope the outcome of the intervention to be? (IT Support only)** |
|  |

|  |
| --- |
| **Parent/Carer Comment- Is there anything else you would like us to know?** |
|  |

|  |  |
| --- | --- |
| 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)** |  |

|  |
| --- |
| **Privacy Notice**  Southampton City Council is collecting this information in order to perform this service or function, and if further information is needed in order to do so, you may be contacted using the details provided. In performing this service, the council may be required to share your information with other organisations or departments, but it will only do so when it is necessary in order for the service to be provided.  The council may also share personal information for the purposes of the prevention, investigation, detection or prosecution of criminal offences, but will not share personal information, or use it for this, or any other purpose, unless provided for by law.  **More detailed information about the Council’s handling of your personal data can be found in its privacy policy, available online (**[**http://www.southampton.gov.uk/privacy**](http://www.southampton.gov.uk/privacy)**), or on request.** |

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