

EDUCATION IMPROVEMENT TEAM - SEND

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| **SENSORY IMPAIRMENT SERVICE*****Parental Consent Form to be completed prior to involvement***  |

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| **Please tick box of service required:****🞎 Hearing Impairment 🞎 Vision Impairment**  |

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| **PUPIL’S DETAILS** |
| **Surname:** | **First Name:** |
| **Gender:** | **Date of Birth:**  | **Year Group:** |
| **Religion:** | **Home Language:** |
| **Ethnicity:**  | **Name of School /setting:** |
| **Home Address:** |
| **Home Telephone:**  | **Mobile:** |
| **E-mail address:** |  |
| **Parent(S) / CAREr(s)’ DetAIls***Note to referrer: Where parents live separately and have joint parental responsibility, only one needs to sign but please ensure both are consulted about this requests* |
| **Name of parent/ carer** | **Relationship to child** | **Parental responsibility?** *Please ✓ or ×* |
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| **Address and postcode:****E-mail address:** | **Telephone:**  |
| **Is there anyone else with parental responsibility?** **YES / No** *(please delete)* |
| **Name:** | **Relationship to child** | **Parental responsibility?** *Please ✓ or ×* |
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| **Address and postcode:****E-mail address:** | **Telephone:**  |
| *Please note written information will be sent to this person unless otherwise indicated* |
| **SIBLINGS’ DETAILS** |
| **Name of brother / sister** | **Age** | **Hearing or Vision Loss** | **School / college attended** |
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| **ADDITIONAL AGENCY INVOLVEMENT** |
| **Service** | **Practitioner’s name** | **Contact number** |
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| **Does the pupil have an Early Help Assessment? YES / No** *(please delete)***If yes, Lead Practitioner’s name:**  |
| **GP Name & practice address:** |
| **REASON FOR REQUEST:****Please give details of reason for request for involvement:** *Complete before parent/ carer signs their consent* |
| **Using your personal information**We will pass on or share information with other services who may be involved in working with you or your family with your consent except if there is a legal requirement or if there is a serious  risk of harm or threat to life. Under the General Data Protection Regulation, you can see your own personal information and can withdraw your consent at any time. For more information on this please read our Privacy Notice. We require your consent for a Specialist Teacher or Specialist Support Assistant to be involved. This may involve consultation with staff, your child being observed in class and/or spending individual time with the Sensory Impairment Service. ***Please read, initial and sign below.*** |

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| **SIGN TO GIVE YOUR consent:** |
| *Please initial* | **I understand the reason for the request as stated above and give consent for my child to be referred to the Specialist Teacher or Specialist Support Assistant from the Sensory Impairment Team.** |
| *Please initial* | **I have read / been given** *(please delete as applicable)* **A copy of the Sensory Impairment Service Privacy Notice; and understand that personal information will be held by the service in accordance with this information.**  |
| *Please initial* | **I give consent for the service to contact other agencies which have had involvement and for reports to be shared with other agencies unless I specify otherwise.**  |
| **Parent/ carer’s signature:** | **Parent /carer’s name**  |
| **Relationship to child:** | **Date:** |
| *Note to referrers*: *we accept referrals via post or a scanned pdf using a Knowsley secure email address.*  |
| **Signature of Referrer:**  | **Referrer’s name:**  |
| **Designation:** | **Date:** |
| ***Please send the completed consent form and supporting information to:***Knowsley Sensory Impairment Service, c/o Southmead Children’s Centre, Sherwood Drive off Lickers Lane, Prescot, Liverpool. L35 3XZTel: 0151 443 2983*Or via Knowsley secure email for*: Vision Impairment: janet.gallagher@knowsley.gov.uk Hearing Impairment: paula.harding@knowsely.gov.uk**Updated: January 2021** |