

Parent Consent for Allied Health Consultation

This form provides permission to allow an Allied Health Professional (AHP) to access your child at the centre and any information they deem necessary for your child's therapy. This consultation must be conducted in a supervised area of the centre, in view of your child's educator(s).

This person **must be 18 years or older and will be asked to produce photo ID to verify their identity at their first attendance at the centre.**

Please complete the entire form, clearly and IN BLOCK LETTERS:

I, _____ parent of _____ give
(Parent/Guardian Full Name) (Child's Full Name)

permission to _____ of;
(Full Name of Allied Health Professional)

Practice Name: _____

Practice Address:

Phone: _____ Email: _____

A regulatory requirement is that we verify the AHP has a clear Working with Children's Check **prior to their attendance at the centre**, to complete this verification please obtain their:

WWCC registration number: _____ Date of Birth: / /

Persons not previously authorised or mentioned on this form **do not have permission to access your child. Please contact the centre immediately if you have any questions or concerns.**

(Parent/Guardian Full Name)

(Signature)

(Date)

OFFICE USE ONLY

- WWCC verification attached.
- Photo ID verified & attached.
- Induction briefing & sign-in/out obligations.