****

**Education Inclusion Services**

**Sensory Support Team**

**PO Box 634 Barnsley S70 9GG**

**Tel no: 01226 773577**

**Consent Form**

**Child’s details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Surname** | **Forename** | **Date of Birth** | **Year group** | **Gender** |
| **Address** | **Parent(s)/Carer(s) Name(s)****Contact number(s)** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SEN support** | **EHCP** | **Looked after child** | **EHA** | **CIN or CP** |
|  |  |  |  |  |

**Requester’s Details**

|  |  |
| --- | --- |
| **Name and Role:****Signature:** | **Setting:****Address:** **Name of SENCo:** |
| **Date of request:**  | **Email and Telephone:** |

|  |
| --- |
| **Outline of strengths and difficulties and reason for request for service involvement** |
| **Please enclose a copy of current SEN Support Plan and latest review and any supporting medical information** |

|  |
| --- |
| **Consent for direct involvement** **To access Sensory Support Service involvement both boxes below need to be signed** |
| **Parent(s)/Carer(s) name(s):** | **Parent’s/Carer’s (person with parental responsibility) signature:** | **Date:** |
| **I agree to my child having direct involvement with Sensory Support practitioner/s/ and understand that BMBC will not collect any information that is not needed to provide and oversee this service. I agree that any relevant information will be shared with appropriate professionals such as other BMBC services and Health professionals and that BMBC will not share my information with anyone else without my consent.** |  **\*Please sign here if you agree\*** |  |
| **I give my permission for BMBC to retain and process this information for the purpose outlined above, as without this BMBC cannot provide this service.  I am aware that I can withdraw consent at any time. If I decide that I no longer wish for the service to be involved, I will contact the Inclusion Service at the above address or 01226 773577 so that they can remove my child’s details from their records.**  | **\*Please sign here if you agree\*** |  |

**In order for the Sensory Support Service to obtain medical information about your child please complete this section**

|  |  |  |
| --- | --- | --- |
| **I agree to the Sensory Support Service seeking medical information regarding my child from the clinic he/she attends. Information is usually sent in the form of a letter to the consultant ophthalmologist / optometrist / orthoptist/ audiologist involved with your child. The information received will be treated confidentially and used only for educational purposes.****My child attends ……………………………………… hospital /clinic** | **\*Please sign here if you agree\*** |  |

*At BMBC we are committed to protecting and respecting your privacy. For further details on how your information is used, how we maintain the security of this and your rights to access the information we hold about you, please refer to www.barnsley.gov.uk/privacy.*