



**ACT Inclusion Support Agency  
 Parent/Guardian Consent Form**

I, (parent/guardian) \_\_\_\_\_ give permission for (name of service) \_\_\_\_\_ to share information regarding my child with ACT Inclusion Support Agency to assist with his/her inclusion into the program.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Child's Information					
Name:					
Date of Birth:					
Days child attends (please circle)	M	T	W	T	F

I give my permission for the ACT Inclusion Support Agency to liaise with, and share information about my child with the following agencies/professionals already supporting the care and education of my child.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Agency/professional	Key Contact	Phone
Behaviour Support Unit		
Clinical Psychologist		
Therapy ACT (please specify OT, speech, physio etc)		
Early Intervention Unit/Special School		
Private Therapist (please specify OT, speech, physio etc)		
Social Worker/ Case Manager		
Pediatrician		
Other		