

APPENDIX THREE NEW APPLICATION FORM 2007
**Application form for the provision of Occupational Therapy
 and/or Physiotherapy Services for students with Moderate
 Physical Disabilities**

Section One

Referring School to Complete:

Name of School:

School Number:

School Address:

Phone: Fax:

Email:

School Contact Person:

Student's Name:

 (Family name) (Given Name)

Date of Birth: Gender:

Ethnicity :

Class Level:..... First Language:.....

Disability / Condition (if known):

Has an application been made to the Ongoing and Reviewable
 Resourcing Schemes? Yes / No
 If yes, what was the result?.....

Date of Application(s): / /

Is the student a client of ACC? Yes / No

Is the student receiving any other Special Education support
 during the current school year?

SHNF School High Health Need Fund Yes/No

SLS Supplementary Learning Support Yes/No

RTL Resource Teacher of Learning and Behaviour Yes/No

SEG Special Education Grant Yes/No

Other, please specify:

Is the student currently receiving any occupational therapy and/or physiotherapy services, possibly from another agency?

Indicate other relevant professionals or agencies involved with this student

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Has the child got a current IEP? If yes, please attach

SCHOOL CONSENT

I undertake to provide information, support and access to school-based resources to enable the contracted service provider to work with this student in school. Eg.. Teacher aide.

I will ensure the student's parents are kept informed and involved throughout the process.

I acknowledge that the school will be responsible for integrating any therapy programme or strategies into regular classroom practice and will support an IEP process by organising, attending and writing up the IEP

Principal:.....

Date:.....

Parent/Caregiver to Complete:

What concerns do you have regarding your child's participation and learning related to their physical skills?

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Which of these concerns would you consider priority for therapy support?.....

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I give consent for this application to be made on behalf of my son / daughter. I agree to a therapist visiting my child in their classroom and consulting with their teacher for the purpose of determining eligibility for services.

(Name of student).....

Student's Home Contact Details:

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I give permission for the Ministry of Education or their contracted service providers to have access to information regarding

.....(name of student).

This information is being collected by the Ministry of Education. The information is collected for the purpose of providing services to meet the special educational needs of students. The collected information may also be used for statistical and research purposes but if used in this way the information will be in a form that means the individual person is not able to be identified. None of the information concerning any individual will be passed on to any other agency without the permission of the individual concerned. Any individual about whom the information is collected is able to access the information and has the right of correction in relation to that information.

Parent/Caregiver Name:

Parent/Caregiver Signature:.....

Date:

Phone number:.....

Email:.....

TEACHERS:

Within the context of the National Curriculum framework, please consider how the student's physical impairment impacts on their participation and learning in each curriculum area

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For this student which issues would you like the therapist support to focus on?

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Describe how the student:

1. Moves around the school environment (eg. in class, accessing the desk, steps, through doors, transitioning between areas/classes, recreational movement(games and playground). Please comment on any equipment/aids used

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2. Uses materials and tools for learning eg. writing tools and materials, art material, technology, maths equipment. Describe any adaptations made to tools or material

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3. Manages self, eg. toileting and hygiene, lunch and snacks, clothing, managing personal belongings, setting up and packing up

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For this student , which issues related to the above would you like the occupational and/or physiotherapy support to focus on?.....

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CHILD: (Consider child’s voice first. If child unable to express, consult with parents/teachers)

What are the child’s concerns and their priorities?

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For office use only:

Application number:..... Date received: / / Date of first contact: /

Date **Accept** **Decline**