USC AUSTRALIA

**USC Child & Youth Occupational Therapy Clinic**

**Parent/Caregiver Permission Form**

Full Name of Child: ____________________________________________________________

Date of Birth: _________________________________________________________________

Please read and tick the following and sign the consent form below:

- ☐ I DO give consent for my child _________________________________ (name of child) to receive occupational therapy services from the University of the Sunshine Coast Child & Youth Occupational Therapy Clinic from occupational therapy students with in-direct supervision from a Clinical Placement Trainer who is a qualified occupational therapist.
- ☐ I acknowledge that therapy provided to my child is provided by occupational therapy students who are training to become occupational therapists and as such quality of services provided may vary from student to student and may not be equivalent to a qualified, registered occupational therapist.
- ☐ I understand that I can contact the Clinical Placement Trainer, Cate Hilly on 0409612884 or chilly@usc.edu.au if I have any concerns about the services provided.
- ☐ I understand that all records regarding my child will be stored securely and confidentiality as part of my child's occupational therapy file that will be maintained in accordance with the provisions of the *Information Privacy Act 2009* (QLD) at the University of the Sunshine Coast.
- ☐ I acknowledge that records may include the gathering of photographic and/or video material, but that this material will not be used for any other purposes without my consent. All such materials will be securely stored and remain confidential as part of my child's occupational therapy file.
- ☐ I understand that services may be provided at my child's school/Kindy and will involve communication with education staff regarding the best way to support my child at school.
- ☐ I consent to Education Queensland/school/kindy staff releasing previous assessment reports and information about my child, such as assessments completed by a Guidance Officer or allied health professionals.
- ☐ I understand that details of the therapy provided to my child may be provided to education staff/allied health professionals/other referrers involved in the therapy and education needs of my child in a report at the end of the Clinic and I will get a copy of this report too.
- ☐ I understand that information about these occupational therapy services may also be released as required by law.
- ☐ I have read and understood details in the Information for School Staff and Families brochure.

I am happy to be contacted by USC to provide a healthcare service user perspective for teaching purposes and/or research Yes No (please circle)

Signature: ___________________________________ Date: ______________________

Parent/Guardian name: _________________________________________________________

Witness Signature: ___________________________________ Date: ______________________

Witness name: _________________________________________________________________