UPWEY SOUTH
Primary School

*To elevate the health and well-being of our school communities through collaborative communication and counselling excellence*

# Please fill out all information on both sides of this form and return it to the relevant staff member

## Counselling School Program Referral Form

**Child's name:** _____

**Date of Birth/ Age:** _____

**Class:** _____

**Reason for Referral:**

_____

_____

_____

_____

**Teacher:** _____

**Teacher's e mail:** _____

**Name of Parents:** _____

In signing this document, we accept that Carvin the counsellor can contact me and accept the conditions attached (consent form) and give permission for our child to be seen by the professional counsellor.

**Signed:** _____ **Relationship to child:** _____ **Date:** _____

**Parents contact details:** _____

Please read and sign the consent form attached. Once signed please keep a copy for yourself.

# Consent form

I consent to the treatment of my son/daughter/ward. I agree to the following

1. Treatment will be provided by Carvin Winans, a professional independent counsellor.
2. The sessions will be held at the school premises, or via Telehealth. Carvin will liaise with teachers, other allied health staff, the principal to discuss the child's behaviour and gather information about the child. As such the sessions themselves with the child/ parent remain confidential.
3. All information gathered during the sessions will remain with the Carvin for medico- legal reasons.
4. Carvin may use the relevant information collected to discuss with educational personnel and other professionals mainly with the view to improving and supporting learning. Carvin will provide care within the standards of the profession.

**Name (Parent/Guardian): _____**

**Signature: _____ Date: ____/____/_____**

**Name (Parent/Guardian): _____**

**Signature: _____ Date: ____/____/_____**