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As part of our preparation for 2026, if you anticipate that your child will access the provision of external therapy at school, please complete **Sections A, B and D**. Alternatively, if you do not want your child to access this service at this time, please complete **Sections A, C and D**.

I/we give consent for the release of information between my/our child's therapy provider, SchoolTherapy and Belridge Secondary ESC. (please circle)		YES / NO	
SECTION A			
STUDENT DETAILS			
Student Name			
Student Date of Birth			
Student Class (Completed by office staff)			
SECTION B			
CAREGIVER DETAILS			
Caregiver 1 Name		Caregiver 1 Phone	
Caregiver 1 Email			
Caregiver 1 Relationship to Child			
Caregiver 2 Name		Caregiver 2 Phone	
Caregiver 2 Email			
Caregiver 2 Relationship to Child			
THERAPIST DETAILS (If known at this time)			
Therapist 1 Name			
Therapist 1 Email			
Therapist 1 Phone		Therapist 1 Job Title	

Therapist 2 Name			
Therapist 2 Email			
Therapist 2 Phone		Therapist 2 Job Title	
Therapist 3 Name			
Therapist 3 Email			
Therapist 3 Phone		Therapist 3 Job Title	

SECTION C

My Child will not be having a therapist visit on site at this time	<input type="checkbox"/>
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SECTION D

Date		Caregiver 1 Name		Signed	
Date		Caregiver 2 Name		Signed	