



Authorisation for Allied Health Professional Visit

Date: _____

Child's name: _____

Please tick the Session your child will be attending: Before School After School Vacation Care

Onsite School Location: _____

Name and Contact details of Person / Organisation managing the Session

Name: _____ **Organisations Name:** _____

Contact Details: _____ **Contact Details:** _____

Please write times your child will with the Allied Health Professional

	Monday	Tuesday	Wednesday	Thursday	Friday
Before School	<input type="radio"/> Start Time: <input type="radio"/> Finish Time:	<input type="radio"/> Start Time: <input type="radio"/> Finish Time:	<input type="radio"/> Start Time: <input type="radio"/> Finish Time:	<input type="radio"/> Start Time: <input type="radio"/> Finish Time:	<input type="radio"/> Start Time: <input type="radio"/> Finish Time:
After School	<input type="radio"/> Start Time: <input type="radio"/> Finish Time:	<input type="radio"/> Start Time: <input type="radio"/> Finish Time:	<input type="radio"/> Start Time: <input type="radio"/> Finish Time:	<input type="radio"/> Start Time: <input type="radio"/> Finish Time:	<input type="radio"/> Start Time: <input type="radio"/> Finish Time:
Vacation Care	<input type="radio"/> Start Time: <input type="radio"/> Finish Time:	<input type="radio"/> Start Time: <input type="radio"/> Finish Time:	<input type="radio"/> Start Time: <input type="radio"/> Finish Time:	<input type="radio"/> Start Time: <input type="radio"/> Finish Time:	<input type="radio"/> Start Time: <input type="radio"/> Finish Time:

- I understand that the Allied Health Professional may use different forms of Digital Technology if it pertains directly to the learning and development of my child.
- I understand that the Allied Health Professional has been provided with ACI's Safe Use of Digital Technologies and Online Environments Policy.
- I understand that while the Allied Health Professional is at the Service, they must remain within the boundaries and play areas that have been set by the Coordinator/Responsible Person.
- I understand that my child will remain under the direct supervision of the OOSH Staff at all times - remain in sight and hearing of the OOSH Staff.

Parent/Authorised Nominee Name: _____

Signature: _____

Date: _____

Coordinator/Responsible Person Name:

Signature: _____

Date: _____