



Authorisation for Allied Health Professional Visit

Only to be used when Session will be in an Area that is **not** directly Supervised by an Educator

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 not be in care

	Monday	Tuesday	Wednesday	Thursday	Friday
Before School	<input type="radio"/> Leaving at <input type="radio"/> Returning at <input type="radio"/> Not returning	<input type="radio"/> Leaving at <input type="radio"/> Returning at <input type="radio"/> Not returning	<input type="radio"/> Leaving at <input type="radio"/> Returning at <input type="radio"/> Not returning:	<input type="radio"/> Leaving at <input type="radio"/> Returning at <input type="radio"/> Not returning:	<input type="radio"/> Leaving at <input type="radio"/> Returning at <input type="radio"/> Not returning:
After School	<input type="radio"/> Leaving at <input type="radio"/> Returning at <input type="radio"/> Not returning	<input type="radio"/> Leaving at <input type="radio"/> Returning at <input type="radio"/> Not returning	<input type="radio"/> Leaving at <input type="radio"/> Returning at <input type="radio"/> Not returning:	<input type="radio"/> Leaving at <input type="radio"/> Returning at <input type="radio"/> Not returning:	<input type="radio"/> Leaving at <input type="radio"/> Returning at <input type="radio"/> Not returning:
Vacation Care	<input type="radio"/> Leaving at <input type="radio"/> Returning at	<input type="radio"/> Leaving at <input type="radio"/> Returning at	<input type="radio"/> Leaving at <input type="radio"/> Returning at	<input type="radio"/> Leaving at <input type="radio"/> Returning at	<input type="radio"/> Leaving at <input type="radio"/> Returning at

- ☐ I accept that my child will not be under the Supervision of Activity Centres Inc Educators when attending a Therapy Session with an Allied Health Professional during OOSH Sessions.
- ☐ I understand that Activity Centres Inc. Educators are not responsible for my child while they are not in their care.
- ☐ I authorise the Coordinator/Responsible Person to sign my child out of care to attend an unsupervised Therapy Session with the Allied Health Professional.
- ☐ I authorise the Coordinator/Responsible Person to sign my child back into care after their Therapy Session with the Allied Health Professional.

Parent / Authorised Nominee: _____ Signature: _____

Coordinator Name: _____ Signature: _____