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 Victoria 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 Victoria Procyk, a professional independent counsellor.
2. The sessions will be held at the school premises, or via Telehealth. Victoria 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 Victoria for medico- legal reasons.
4. Victoria may use the relevant information collected to discuss with educational personnel and other professionals mainly with the view to improving and supporting learning. Victoria will provide care within the standards of the profession.

Name (Parent/Guardian): _____

Signature: _____ Date: ____/____/_____

Name (Parent/Guardian): _____

Signature: _____ Date: ____/____/_____