

NDIS consent form

School Name _____

Student Name _____

Are you funded for NDIS: Yes No

If yes please provide NDIS Plan Number _____

Would you like assistance to apply for NDIS? Yes No

You can contact Grow Wellbeing on ndis@growwellbeing.com

I / we would like Grow Wellbeing to contact me to discuss my options re the provision of NDIS mental health care therapies operating within our school community.

1. I / we acknowledge that the role of Grow Wellbeing is to provide therapeutic support for the student, consult with educational personnel and any other relevant professional concerning possible outcomes and ongoing consultative support, treatment and assessments for each student.
2. I / we acknowledge that Grow Wellbeing staff may contact persons who are or have been directly concerned with the care or education of each student (such as teachers, therapists and doctors) to seek information about the student's background, abilities and performance that may be relevant to the service being provided.
3. I / we acknowledge that no sharing of personal and confidential information will occur without explicit written expression from the guardian (s) or client of consenting age.

Name (Parent / Guardian) Name (Parent / Guardian)

Signature..... Signature.....

Date