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Description automatically generatedBullimbal School for Specific Purposes**

18-36 Degance Street

Tamworth, NSW 2340

**Phone:** 6762 8003

**Fax:** 6762 8007

**Mobile:** 0407 582 813, 0480 261 652, 0480 342 343

**Administration Email:** [bullimbal-s.school@det.nsw.edu.au](mailto:bullimbal-s.school@det.nsw.edu.au)

**Therapists Email:** [bullimbaltherapists@gmail.com](mailto:bullimbaltherapists@gmail.com)

**Parent Request for External Therapy**

|  |  |  |
| --- | --- | --- |
| **STUDENT DETAILS** | | |
| Student Name |  | |
| **REQUEST DETAILS** | | |
| Type of Service | Therapist Name | |
| * Speech Therapy * Occupational Therapy * Physiotherapy * Behaviour Support * Exercise Physiology * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | |
| Frequency of Service | Duration of Service | |
| * Weekly * Fortnightly * Monthly * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Term 1 * Term 2 * Term 3 * Term 4 | |
| **ACKNOWLEDGEMENT** | | |
| * I understand that should no suitable times be available in my child’s class the service cannot commence * I agree to the therapist sharing information about my child and their progress with the school * I agree to contact the school immediately if ceasing therapy | | |
| Parent/Carer Full Name | Signature | Date |
|  |  |  |