

MOE, Learning Support, Waikato Phone: 0-7-850 8880

DX Box GX10047, Hamilton Free Ph 0800 622 222

19 Home Straight, Te Rapa [www.education.govt.nz](http://www.education.govt.nz)

Hamilton 3200

**Can Ministry Of Education Support You?**

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| **Legal Guardian consent for referral**:  Verbal 🞏 Written 🞏 | **Office Use:**  **Ref Received Date:** |

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| **Child’s Name**  *Underline family name* |  | | **DOB:** |  |  | | M  F |
| **Primary Caregiver(s) - 1** |  | | **Other**  **Caregiver(s) - 2** | |  | | |
| **Relationship** |  | | **Relationship** | |  | | |
| **Legal Guardian** | **YES NO** | | **Legal Guardian** | | **YES NO** | | |
| **Primary home address:** |  | | **Contact Details:** | |  | | |
| **Email:** |  | | **Email:** | |  | | |
| **Phone:** | |  | **Phone:** | | | **Mob:** | |

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| **Ethnicity (1):** |  | **Iwi Affiliation:** |  |
| **Ethnicity (2):** |  |  |  |
| **Ethnicity (3):** |  |  |  |
| **Main languages spoken at home:** | | | |

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| **EC Service / School:** |  | **Year:** |  |
| **Facility Address:** |  | **NSN:** |  |
| **Contact person at EC Service / School:** | | **Phone:** |  |

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| **Referrer Name:** |  | | | **Role:** |  | |
| **Agency Name &**  **Address:** |  | | | | | |
| **Referrer’s Ph:** |  | | | **Email:** |  | |
| **Referred for:** | Early Intervention | School Communication | School Behaviour | School  Complex Needs | | Other |

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| **Please ensure the parent/caregiver has seen and agrees with the following information** |
| **What is your reason for referring?** (eg the child’s behaviour, communication skills, general development). What assistance/skills are needed by management/teacher/kaiako? |
| ***PLEASE RETURN THIS FORM TO: Business Support, Ministry of Education, DX Box GX10047, Hamilton***  ***OR Email: LSWaikato.referrals@education.govt.nz*** |
| **What has already been done to address the concern?** (eg interventions by you or others, hearing tests, information from doctors, etc). Please describe or attach information. |

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| **Permission for Referral** |
| * By signing this form, you are giving permission for information to be used within the Ministry of Education. We will use this information so we can have a discussion with you and/or your child’s Early Childhood Service or school to decide the most appropriate type of support for your child. * Information may be shared with other education or health professionals where it is considered to be in the best interests of the individual concerned. Existing information held by the Ministry of Education may also be used to help decide appropriate service. * Information will be stored in a Ministry of Education office and access to this can be requested from your local Ministry of Education, Learning Support office.   **We agree to the referral being made to the Ministry of Education, Learning Support.** |

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| **AGREEMENT FOR REFERRAL BY SCHOOL PRINCIPAL OR SENIOR TEACHER EARLY CHILDHOOD SERVICE** | **AGREEMENT FOR REFERRAL BY PARENTS / CAREGIVERS / WHANAU** |
| Name:  Designation:  Signature:  Date : | Name:  Designation:  Signature:  Date : |

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| McKenzie Centre:  Conductive Education:  Consent to contact:  Referred to Hospital:  RTLB: | YES / NO / NOT SURE  YES / NO / NOT SURE  YES / NO  YES / NO / NOT SURE  YES / NO / NOT SURE | | | Waitlist / Receiving Services  Waitlist / Receiving Services |
| **ACCEPT / DECLINE / PENDING**  *(Please circle)* | | | | |
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| **Job Type: EI:** JCM JEI JBE | | **SCHOOL:** JCM JSA JMD | | |
| **Expected Service Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **SM Signature:** | | | **Date:** | |