

**SchoolKit Transition Clinic   
Evaluation Letter & Consent Form**

[INSERT DATE]

Dear Parents/ Caregivers,

**Re: Questionnaire on School Transition Clinics**

You are invited to participate in this questionnaire about School Transition Clinic/s at your child’s school. These clinics involve you and your child, school staff, medical staff and may also involve your case manager, other disability support staff and allied health.

This questionnaire is related to your clinic experience, and the information you provide will help us make the transition period from school age to adulthood a better experience for families.

The questionnaire is confidential. No information identifying a person will be released in any publication arising from this study.

Participation is in the questionnaire is voluntary. You will receive the same level of services regardless of whether or not you participate.

Thank you in anticipation for completing this questionnaire. Should you have any questions, please contact [INSERT NAME AND/OR JOB TITLE], on [INSERT PHONE NUMBER] or via email [INSERT EMAIL ADDRESS].

Best wishes,

Dr [INSERT NAME]

Director,

[INSERT NAME OF HEALTH SERVICE]

**CONSENT FORM**

**(Please return this with your questionnaire)**

**Evaluation of School Transition Clinic**

1. I agree to participate in the questionnaire described above.
2. I agree that the results of the questionnaire may be published, provided that I cannot be identified.   
   I understand that I can withdraw from the study at any time without prejudice to my relationship to   
   [INSERT NAME OF SCHOOL] or [INSERT NAME OF HEALTH SERVICE].
3. I understand that if I have any questions relating to my participation in this research, I may contact   
   [INSERT NAME] (by telephone or email) who will be happy to answer them.
4. Complaints may be directed to [INSERT NAME OF HEALTH SERVICE] on phone: [INSERT PHONE NUMBER]

Signature of participant PRINT name Date

Child’s name



**SchoolKit Transition Clinic   
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[INSERT DATE]

Dear School Staff Member,

**Re: Questionnaire on School Transition Clinics**

You are invited to participate in this questionnaire about School Transition Clinic/s at your school. These clinics involve your student and their family, medical staff and may also involve the student’s case manager, other disability support staff and allied health.

This questionnaire is related to your clinic experience, and the information you provide will help us make the transition period from school age to adulthood a better experience for families.

The questionnaire is confidential. No information identifying a person will be released in any publication arising from this study.

Participation is in the questionnaire is voluntary. You will receive the same level of services regardless of whether or not you participate.

Thank you in anticipation for completing this questionnaire. Should you have any questions, please contact [INSERT NAME AND/OR JOB TITLE], on [INSERT PHONE NUMBER] or via email [INSERT EMAIL ADDRESS].

Best wishes,

Dr [INSERT NAME]

Director,

[INSERT NAME OF HEALTH SERVICE]

**CONSENT FORM**

**(Please return this with your questionnaire)**

**Evaluation of School Transition Clinic**

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   [INSERT NAME] (by telephone or email) who will be happy to answer them.
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Signature of participant PRINT name Date