

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

Dear [INSERT NAME PARENTS / CAREGIVERS],

 **Re: Participation in School Transition Clinic**

You have received this letter as your child will soon be leaving [INSERT NAME] School.

To support you in this transition, you are invited to participate in a Multidisciplinary School Transition Clinic that will be held at your child’s school. The role of the Clinic is to ensure your child’s move to adult services is planned and coordinated and also to provide support to you and your family during this period.

The clinic is an opportunity for family/carers, school staff and health professionals to come together to discuss your young person’s needs. The objective is check in on the young person’s progress and provide an opportunity for discussion with the key people involved with their care. Clinics usually last 1-1½ hours. People present may include:

* + - Family and carers
		- The young person (optional)
		- Paediatric medical staff
		- Adult medical staff
		- School staff
		- Allied health staff (e.g. Therapists/ Social Worker)
		- An interpreter can also be arranged if required.

You are welcome to bring along a family member/friend to be a part of the clinic. If there are additional key people involved in the care of your child please let us know so we can arrange an invitation.

Attendance at these clinics is voluntary and your decision not to attend will in no way affect the ongoing support that you receive at school. The meeting is intended to help you to find your way in the adult health system and disability services after your young person leaves school. If you agree to participate please sign the consent form below and return it to your child’s school. The school will then contact our team to arrange a clinic appointment.

I look forward to meeting you and your family in the near future. Should you have any questions, please contact your child’s teacher or principal.

Yours sincerely,

Dr [INSERT NAME]

Director,

[INSERT NAME OF HEALTH SERVICE]



**CONSENT FORM**

**(Please return to your school)**

**Re: Participation in School Transition Clinics**

I give permission for my child’s school [INSERT SCHOOL NAME] to release information to the Multidisciplinary School Transition Team from the Developmental Assessment Service, St George Hospital.

I understand that this information will be used to:

* + make an appointment for my child to attend a School Transition Clinic
	+ facilitate discussion and release of information from my child’s treating clinicians
	+ facilitate discussion of my child’s needs.

I agree to be contacted by a member of the school transition team.

Name of Child and DOB:

Name of Parent/Caregiver:

Signature of Parent/Caregiver Date

Contact phone number

Address

Email address

Additional people I would like to be invited:

Name/s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Role/s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_