**Permission for Input from the Sensory Support Team**

*Please complete this form in BLOCK CAPITALS using* ***BLACK INK****.*

Name of Child or Young Person ………………………………………………….

**Date of Birth** …………………………………………………………………………………………

**Address** ………………………………………………………………………………………….

………………………………………………………………………………………….

………………………………………………………………………………………….

**Telephone** ………………………… **Email Address** …………………………………….

**I give permission for the Sensory Support Team to visit, assess and work with my child at home and/or in educational settings.**

**I consent to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hospital sharing information about my child with the Sensory Support Team.**

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For information on how we process your data, please see the [West Sussex Sensory Support Team Privacy Notice](https://www.westsussex.gov.uk/about-the-council/information-and-data/data-protection/privacy-notices/sensory-support-team-privacy-notice/)

On the other side of this form please provide the name and contact details of key professionals already working with your child.

Please return this form to the address below or email to [sensory.support@westsussex.gov.uk](mailto:sensory.support@westsussex.gov.uk)

**Names and contact details of key professionals already working with my child**

|  |  |  |  |
| --- | --- | --- | --- |
| Health Visitor/ School Nurse |  | Clinical Psychologist |  |
| Specialist consultant e.g., Paediatrician |  | CAMHS team |  |
| Specialist nurse |  | Social Services |  |
| Child Disability Team |  | Portage Home Visiting Education Service |  |
| Physiotherapy Service |  | Children and Family Centre worker |  |
| Speech & Language Therapy Service |  | FIRST team |  |
| Occupational Therapy Service |  | Voluntary Agencies/Services |  |
| Educational Psychologist |  | Other |  |
| Audiology/ENT Department |  | Eye Department |  |