

## PRESCHOOL FIELD OFFICER SERVICE

## 2019 REQUEST FOR SUPPORT - INDIVIDUAL CHILD

**This support request will focus specifically on the individual child**

**To access this service children must be 3 years or older before 30 April 2019**

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|  **The educator(s) must be available to meet during a mutually agreed time.****Please contact the Wyndham City PSFO Service on 9742 8199 if you have any questions about this form.****Send completed forms and any supporting documentation by email to: psfo.service@wyndham.vic.gov.au****Or post to: PSFO Administration, Wyndham City, PO Box 197, Werribee VIC 3030** |

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| **PARENT/FAMILY SECTION** |
| **CHILD’S DETAILS** |
| Child’s Name: |  |
| Date of Birth: |  |  Gender: | 🞏 Male 🞏 Female 🞏 Non-identified |
| Home Address: |   |  | Suburb: |
| Is the child: |  🞏 Aboriginal  |  🞏 Torres Strait Islander  | 🞏 Both Aboriginal and Torres Strait Islander  |
| Country of Birth: |  | Language(s) spoken at home: |  |
| Proficiency Spoken English:  | 🞏 Very Well | 🞏 Well | 🞏 Not Well | 🞏 Not at all |

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| **PARENT/GUARDIAN DETAILS** |
| Child lives with:  |  🞏 Both parents  |  🞏 Mother  |  🞏 Father  | Other: |
| **Carer 1** | Name: |  |  | DOB:  | Relationship to Child: |  |
| Phone  | Home: |  | Work: |  | Mobile: |  |
| Email: |   | Preferred Language: | Country of Birth: |
| **Carer 2** | Name: |  | DOB:  | Relationship to Child: |  |
| Phone  | Home: |  | Work: |  | Mobile: |  |
| Email: |  | Preferred Language: | Country of Birth: |

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| Is this the child’s second year of funded 4 year old Kindergarten?  |  🞏 Yes 🞏 No  |
| Has the child had their 3 1/2 year old Maternal Child Health check?  | 🞏 Yes  | 🞏 No  |
| Does your child attend any other early years’ service along with the service who are referring? 🞏 Yes 🞏 No If Yes, where and when?  |

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| **SIBLINGS** |
| **SIBLING 1** | **SIBLING 2** | **SIBLING 3** | **SIBLING 4** |
| Name: |  | Name: |  | Name: |  | Name: |  |
| Gender: | 🞏 Male 🞏Female | Gender: | 🞏 Male 🞏 Female | Gender: | 🞏 Male 🞏 Female | Gender: | 🞏 Male 🞏 Female |
| D.O.B: |  | D.O.B: |  | D.O.B: |  | D.O.B: |  |

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| Does your child have a diagnosis or undergoing assessment for developmental concerns? | ❑ Yes ❑ No |
| If Yes, please provide details |
| Is your child currently receiving support through Brotherhood of St Laurence or NDIS? (**If Yes**, please note PSFO Services are not available to children who are already receiving support through these agencies) | ❑ Yes ❑ No |
| Is your child currently waiting for support through Brotherhood of St Laurence or NDIS? | ❑ Yes ❑ No |

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| **Other services the child has been receiving or has been referred to – please provide information below and attach relevant reports.**  |
| Services | Name of Agency | Name ofProfessional |
| Speech Therapist |  |  |
| Paediatrician |  |  |
| Psychologist |  |  |
| Occupational Therapist |  |  |
| **Contact will be made with the listed agencies (where appropriate) to assist in developing consistent strategies. If you do not wish these services to be contacted, please tick here** ❑ |

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| **What does your child do well?** |
| **What would you like to happen for your child over the next 12 months?** |
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| **Is there anything occurring in your child’s life now that may be impacting on their learning and development?**  |
| **Parent/Guardian level of concern (please tick)** |  **🞏 Concerned**  | **🞏 Not Concerned**  |

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| **EDUCATOR SECTION** |
| **SERVICE INFORMATION** |
| Name of Centre: |  | Phone: |
| Address: |  | Suburb: |
| Contact email: |
| Educator 1 - Name: | Position: |
| Educator 2 - Name: | Position: |
| Educator 3 - Name: | Position: |

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| **Please provide child’s attendance times for each day (e.g. 8.30am to 12.30pm)** |
|  | *Example* | Monday | Tuesday | Wednesday | Thursday | Friday |
| Start | *9.00* |  |  |  |  |  |
| End | *3.30* |  |  |  |  |  |
| Group Name/Colour |  |
| Educator Planning (day/time) |  |
| Please tell us the best day and time of the week to make contact |  |
| Is this child attending your funded 4 year old program? | **🞏** Yes  | **🞏** No |
| Have you utilised the Preschool Field Officer Service before for this child? | **🞏** Yes  | **🞏** No |

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| **SUPPORT INFORMATION** |
| Please select one of the following options: |
|  **🞏** |  **4 Year Old Support** | **🞏** | **3 Year Old Support** |

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| **Please indicate what you require support with:** |
| ❑ | Child observation | ❑ | Support with referral pathways |
| ❑ | Educator consultation(s) | ❑ | Communicating with Parents |
| ❑ | Strategies (please answer question below if you have ticked this box)Have you completed the Early ABLES online tool ❑Yes ❑No |
| *The VEYLDF supports children’s learning and development by enabling all early childhood professionals to work together and with families to achieve common outcomes for all children. It sets the highest expectations for children in every community and generates opportunities to advance all learning and development outcomes (p26).* **What outcome(s) would you like to achieve from working with the PSFO Service?** Please enter as much info as possible and use a separate sheet if needed. |

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| **CHILD SECTION** |
| **For the Early Childhood Educator to complete in consultation with the child.**Please complete this section with the child. If the child is non-verbal it is suggested this section is still fully completed by including statements as shown in the examples below:*Sally will play in close proximity to Jane on a regular basis.**Sally will often play in the sandpit and smiles when she is being pushed on the swings.**Sally avoids water play and washing her hands.* |
|  | **I feel happy when:** |
|  | **I feel sad when:** |
|  | **I like:** |
|  | **I don’t like:** |
| **My friends are:** |

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| **CONSENT OF PARENT/GUARDIAN** |
| * We/I have read the information above and consent to its collection and to the involvement of the Preschool Field Officer Service with my child
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| * My/our child’s Educator has discussed with me/us their concerns and the reason for requesting support
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| * We/I have received a copy of this form
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| * We/I understand that either parent/guardian(s) named on page 1 of this form can be contacted with regards to this form if required
 |
| * Wyndham City Council is bound by the *Privacy and Data Protection Act* 2014 and the *Health Records Act* 2001.  •Your consent is required for the collection and use of your personal and/or health information and that of your child. •The information is being collected by Council for the purpose of delivering services to your child by the PSFO Service; it will be used by Council and it may be shared with educators, early intervention, health and welfare service providers for the purposes mentioned.    •Your information will be stored in Council’s Customer Database and used to identify you when communicating with Council and for Council to deliver services and information to you.  •Disclosure of information may occur to other persons or agencies with consent by both parents; or the authorised parent/guardian; or as permitted by law.    •For further information on how your personal and health information will be handled, see Council’s Privacy Policy on its website. •Authorised parents and guardians may apply for access and/or amendment of the information by writing to Council’s Privacy Officer.
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| **Parent/Guardian Signature** |  | Print Name |  | Date |  |

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| **Requesting Educator Signature** |  | Print Name |  | Date |  |

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| **If the request was not made by the child’s Early Childhood Educator, please complete the below** |
| Agency Name: |  | Phone: |  |
| Contact Name: |  | Email: |  |
| Signature: |  | Date: |  |

