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| **Application to NCSE for** **Resource Teaching Hours for** **Students with Down Syndrome** |
| 1. Schools should use this form to apply for resource teaching hours to enable them to support students with Down Syndrome who have not been allocated low incidence resource teaching hours.
2. A professional report(s) confirming a diagnosis of Down Syndrome must be submitted with this form.
3. Schools must have the consent of the parent(s)/guardian(s) to make the application (See part D).
4. The Declaration at end of this form must be signed by the Principal of the school.
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| 1. **STUDENT DETAILS**
 |
| **Name of Student** |  | **Gender**  | **M** | **F** |
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| **Home Address of Student** |  |
| **PPSN** |  | **Date of Birth** |  |
| **Date enrolled in school** |  | **Class or Year group**  |  |
|  **B. SCHOOL DETAILS** |
| **Name of School** |  |
| **Address of School** |  |
| **School roll number** |  | **Phone Number** |  |
| **Email address** |  | **Name of Principal** |  |

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| **C. PROFESSIONAL REPORT(S) INCLUDED IN SUPPORT OF THIS APPLICATION** |
| **Please specify** **type of professional report** |  | **Author of Report (other details)** | **Date of report(s)** |
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| **D. PARENTAL/GUARDIAN CONSENT** |
| **I/We, the undersigned, being the parent(s)/guardian(s) of the above named student confirm that:*** This application has been discussed with me/us and that I/we give consent to the school to apply for the resource teaching hours identified above.
* I/We understand that all information relating to this application will be kept on file, and made available to the SENO/NCSE and may be used for planning and research purposes with a view to improving the delivery of special education services.
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| **Signed** |  | **Name** |  | **Date** |  |
| **Signed** |  | **Name** |  | **Date** |  |
| **Contact Phone No. for Parent(s)/Guardian(s)** |  |
| **E. DECLARATION BY PRINCIPAL** |
| Iconfirm that:* The school has not been allocated low incidence resource teaching hours for this student under any other category.
* To the best of my knowledge, the information provided in support of this application confirms that the student has Down Syndrome.
* The resource hours granted will be used to provide additional teaching support to the student concerned.
* This Application is supported by the Chairperson of the school’s Board of Management.
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| **Signed**  |  | **Date** |  |

Date received: SENO USE ONLY