***Meadow High School***

*Royal Lane, Hillingdon, Middlesex UB8 3QU*

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***Headteacher: Mrs Jenny Rigby***

***Deputy Headteacher (Royal Lane): Miss Michelle Taylor***

***Deputy Headteacher (Northwood Road): Miss Amy Willis***



3rd April 2025

Dear Parent/Carer,

**Rebound Therapy**

The Therapy team are currently organising Rebound Therapy sessions and feel it would be beneficial for your child to participate. The purpose of the sessions is to develop and enhance both gross motor control and sensory processing. Rebound Therapy is a therapeutic form of trampolining and the therapist is able to target particular areas without impacting the student.

Our intention is to conduct a series of at least six sessions, after which we will review the progress and effectiveness of the programme. These sessions are scheduled to take place one day a week (day TBC) and will be facilitated by our occupational therapists.

Please complete and return the enclosed reply slip to the school as soon as possible. Please also return the medical information.

Should you have any questions or require further information regarding this intervention, please feel free to reach out to any member of the therapy department.

Best regards,

**Therapy Team**

***Article 23:- 'A child with a disability has the right to live a full and decent life with dignity and independence, and to play an active part in the community.'***



………………………………………………………………………………………………………………………

**REPLY-SLIP – Rebound Therapy – please return to Therapy Team**

Pupil Name: …………………………………………………………..Class: ……………. Age: ……..

I give consent for my child to participate in Rebound Therapy sessions.

Signed (Parent/Carer): …………………………………………………… Date: ……………………

**Consent and Medical Form - Rebound Therapy**

| **Does the participant have any of the following?** | **YES** | **NO** | **Comments and Initial** |
| --- | --- | --- | --- |
| Spinal rodding |  |  |  |
| Dwarfism |  |  |  |
| Brittle Bones |  |  |  |
| Pregnancy |  |  |  |
| Atlanto-axial instability (confirmed) |  |  |  |
| Detached retina(s) |  |  |  |
| Osteoporosis |  |  |  |
| Haemophilia |  |  |  |
| Cardiac or circulatory problems |  |  |  |
| Epilepsy |  |  |  |
| Arthritis or Stills Disease |  |  |  |
| Asthma / respiratory problems |  |  |  |
| Cystic Fibrosis |  |  |  |
| Muscular Dystrophy |  |  |  |
| Spina Bifida or Hydrocephalus |  |  |  |
| Changeable muscle tone |  |  |  |
| Dislocated hip(s) / other joint problems |  |  |  |
| Vertigo, blackouts, nausea |  |  |  |
| Hernia / prolapsed |  |  |  |
| Open wound(s) |  |  |  |
| Gastrostomy |  |  |  |
| Incontinence |  |  |  |
| Tracheostomy |  |  |  |
| Recent serious illness/ surgery |  |  |  |
| Tender / Fragile skin |  |  |  |
| Implant (e.g. Baclofen pump) |  |  |  |

Participant’s Name: ………………………………..…………… Date of Birth…………………

Are the any other conditions of which we should be aware? (Continue overleaf if necessary)

…………………………………………………………………………………………………..

I give my consent for the person on this form to take part in Rebound Therapy sessions and I understand that it is my responsibility to inform the session organisers of any changes to the participant’s condition

Name of Adult Completing Form (Print) …………………………………………………

Profession or relationship to participant: ...............………………………………………

Signature: ………………………………………………………Date:……………………

If any of the above conditions are ticked, this form must be signed by a medically trained profession

Parents/carers name: ……………………………………………….……….

Parents signature:………………………………..…………………………..



















