

**School Mental Health Award Contract Form**

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| **Name:** |  |
| **Name of School** |  |
| **Address:** |  |
| **Email Address:** |  |

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| **Identified school lead and main contact for the School Mental Health Award** | |
| **Name:** |  |
| **School Role:** |  |
| **Email Address:** |  |
| **Telephone Number:** |  |

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| **Please sign below to confirm that you are applying for the School Mental Health Award and will complete within 12 months (electronic signature allowed). An invoice will be sent for the value of £350 in the following weeks and is non-refundable** | |
| **Name of Headteacher:** |  |
| **Headteacher Signature:** |  |
| **Name of Chair of Governor:** |  |
| **Please confirm CoG is aware that the school is applying for the award** |  |