Please return **WITH YOUR ECHP** to: Education Liaison Service, St Piers School & College, St Piers Lane, Lingfield, Surrey RH7 6PW. Email: [education@youngepilepsy.org.uk](mailto:education@youngepilepsy.org.uk) Tel: 01342 832243



**Application Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Applicant’s full name |  | | |
| Applicant’s address |  | | |
| Applicant’s postcode |  | | |
| Local authority |  | Date of birth |  |
| Gender (male/female) |  | Nationality |  |
| Religion |  | Home language |  |
| **Applicant’s ethnic origin** | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| White | Mixed | | Asian or Asian British | Black or Black British | Other | |
| British  Irish  Other  Please specify: | White/Black Caribbean  White/Black African  White/Asian  Other  Please specify: | | Indian  Pakistani  Bangladeshi  Other  Please specify: | Caribbean  African  Other  Please specify: | Chinese  Other  Please specify: | |
| Placement commencing  2018  2019  2020  2021 | | | Placement type  Day  Weekly (Mon-Thur boarding)  Termly  48 weeks  52 weeks | | | |
| PARENTAL RESPONSIBILITY: In accordance with The Children Act 1989, Please give full details below of ALL persons with parental responsibility and to whom correspondence, reports invitations etc. should be sent. | | | | | | |
| Have there been any safeguarding or child/adult protection concerns related to this child/young person?  Yes  No | | | | | | |
| Is the young person looked after by local authority?  Yes  No | | If ‘Yes’ is it: Involuntarily through a Care Order  Voluntarily under section 20 or 85 | | | | |
| Parent/Carer 1 | | | | | |
| Name | |  | | | |
| Relationship to applicant | |  | | | |
| Address | |  | | | |
| Postcode | |  | | | |
| Telephone – Home | |  | | | |
| Telephone – Mobile | |  | | | |
| Telephone – Work | |  | | | |
| Parent/Carer 2 | | | | | |
| Name | |  | | | |
| Relationship to applicant | |  | | | |
| Address | |  | | | |
| Postcode | |  | | | |
| Telephone – Home | |  | | | |
| Telephone – Mobile | |  | | | |
| Telephone – Work | |  | | | |
| Deputy/LA Contact Information | | | | | |
| Appointed deputy | |  | | | |
| LA contact name | |  | | | |
| LA contact address | |  | | | |
| Postcode | |  | | | |
| LA contact email address | |  | | | |

|  |  |
| --- | --- |
| **Education Information** | |
| Current or most recent School or College name and address: |  |
| Postcode |  |
| Dates attended | From To |
| **Previous School 1 - Name** |  |
| Location |  |
| Dates attended | From To |
| **Previous School 2 - Name** |  |
| Location |  |
| Dates attended | From To |
| **Previous School 3 - Name** |  |
| Location |  |
| Dates attended | From To |
| **Previous School 4 - Name** |  |
| Location |  |
| Dates attended | From To |
| **Unique pupil number** |  |

|  |  |
| --- | --- |
| Educational levels  national curriculum or  P-levels (if not known please state ‘don’t know’) | Literacy  Numeracy  Science  Other |
| Does the applicant receive additional support in the classroom? If so, for how long? |  |
| Does the applicant have access to the National Curriculum? |  |
| Does the applicant have a modified curriculum? |  |
| Has the applicant ever been refused admission to a school? Please provide details. |  |
| Has the applicant ever been excluded from a school? Please provide details. |  |
| If the applicant is currently not in education please advise why. |  |
| **Other** | |
| Does the applicant have access to a psychologist? Please advise input received: |  |
| Leisure/hobbies/clubs |  |
| Religious or cultural needs |  |
| **Medical Information** | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Does the applicant have seizures? | | Yes  No | | | If yes, please detail seizure types | | |
| Has a seizure ever lasted longer than 30 minutes? | | Yes  No | | | If yes, has this ever required admission to ITU? | | |
| Has the applicant ever required hospital admission in relation to their epilepsy? | | Yes  No | | | If yes, where and when? | | |
| Has medical assistance ever been required to stop a seizure? | | Yes  No | | | Do seizures ever occur in clusters? | | Yes  No |
| Is extra medication required to stop a cluster of seizures? | | Yes  No | | | If yes, please give details | | |
| Has the applicant ever injured themselves during a seizure? | | Yes  No | | | If yes, please give details | | |
| Does the applicant sleep after a seizure? | | Yes  No | | | If yes, please give details | | |
| Are there any behaviour/mood changes before/after a seizure? | | Yes  No | | | If yes, please give details | | |
| Does vomiting occur during or after a seizure? | | Yes  No | | | If yes, please give details | | |
| Does incontinence occur during or after a seizure? | | Yes  No | | | If yes, please give details | | |
| **Medication** | | | | | | | |
| Routine Drug(s) (Name) | Strength | | | Dosage | | When and how administered | |
|  |  | | |  | |  | |
| Emergency Drug(s) Name | Strength | | | Dosage | | When and how administered | |
|  |  | | |  | |  | |
| Does the applicant suffer or require treatment for any of the following? | Yes | | No | Details | | | |
| Diabetes |  | |  |  | | | |
| Asthma |  | |  |  | | | |
| Eczema |  | |  |  | | | |
| Heart Problems |  | |  |  | | | |
| Any Allergies |  | |  |  | | | |
| Any other disability or medical conditions? |  | |  |  | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Has the applicant had any of the following? | | | | | | | | Has the applicant had the following immunisations? | | | | | | | | |
|  | Yes | | No | Date | | | |  | | | | Yes | | No | Date | |
| Measles |  | |  |  | | | | Diphtheria | | | |  | |  |  | |
| Mumps |  | |  |  | | | | Tetanus | | | |  | |  |  | |
| Rubella |  | |  |  | | | | Whooping Cough | | | |  | |  |  | |
| Chicken Pox |  | |  |  | | | | Poliomyelitis | | | |  | |  |  | |
| Rubella |  | |  |  | | | | MMR (measles, mumps, rubella) | | | |  | |  |  | |
| BCG |  | |  |  | | | |  | | | | | | | | |
|  | | | | | | | | Yes | | No | Not now but in the past | | | | | |
| Are there any eyesight problems? | | | | | | | |  | |  |  | | | | | |
| Are there any hearing problems? | | | | | | | |  | |  |  | | | | | |
| Please detail any treatment for these: | | | | | | | | | | | | | | | | |
| **Therapy** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Does the applicant see a speech and language therapist (SLT) at their current school? | | | | | | | |  | | | | | | | | |
| Do you know what they do? | | | | | | | |  | | | | | | | | |
| Do you feel the applicant needs SLT input at Young Epilepsy? | | | | | | | |  | | | | | | | | |
| If so, what areas would you want us to work on? | | | | | | | |  | | | | | | | | |
| **Communication** | | | | | | | | | | | | | | | | |
| How would you describe the applicant’s ability to communicate with people? | | | | | | | |  | | | | | | | | |
| What do you see as their strong points in communicating? | | | | | | | |  | | | | | | | | |
| Please describe any concerns about their communication or areas of communication that still need developing. | | | | | | | |  | | | | | | | | |
| Have they ever used sign language, symbols, objects of reference, PECS, electronic communication aids or a communication book? Please specify. | | | | | | | |  | | | | | | | | |
| **Oral Skills and Hearing** | | | | | | | | | | | | | | | | |
| Does the applicant experience any chewing, swallowing, dribbling or choking problems? Please describe any concerns. | | | | | | | | |  | | | | | | | |
| Have they ever needed tube feeding? | | | | | | | | |  | | | | | | | |
| Do they experience any hearing problems? Please describe any concerns. | | | | | | | | |  | | | | | | | |
| When was the last known hearing test and what was the result? | | | | | | | | |  | | | | | | | |
| Has the applicant attended ENT or Audiology at any hospital? Please say where or when. | | | | | | | | |  | | | | | | | |
| **Occupational Therapy** | | | | | | | | | | | | | | | | |
| Has the applicant had any OT input at school or at home? Do you know what this was for (eg equipment, fine motor skills) | | | | | | | | |  | | | | | | | |
| Do you feel that the applicant needs OT input at Young Epilepsy? If so, what areas would you like is to work on? | | | | | | | | |  | | | | | | | |
| Does the applicant experience any visual difficulties? Please describe any concerns. | | | | | | | | |  | | | | | | | |
| Has the applicant attended any Ophthalmology or Orthoptic appointments at any hospital? Please say where and when. | | | | | | | | |  | | | | | | | |
| **Self-Care**  Please give details of help needed and equipment used | | | | | | | | | | | | | | | | |
| Dressing | |  | | | | | | | | | | | | | | |
| Eating/Drinking | |  | | | | | | | | | | | | | | |
| Toileting | |  | | | | | | | | | | | | | | |
| Shower/Bath | |  | | | | | | | | | | | | | | |
| Grooming (hair, nails, teeth) | |  | | | | | | | | | | | | | | |
| Shaving or hair removal | |  | | | | | | | | | | | | | | |
| Menstruation | |  | | | | | | | | | | | | | | |
| **Transfers**  Can the applicant get on/off or in/out of the following? Please give details | | | | | | | | | | | | | | | | |
| Bed | |  | | | | | | | | | | | | | | |
| Chair | |  | | | | | | | | | | | | | | |
| Toilet | |  | | | | | | | | | | | | | | |
| Floor | |  | | | | | | | | | | | | | | |
| Bath | |  | | | | | | | | | | | | | | |
| **Manual Dexterity**  Can the applicant do the following? Please give details. | | | | | | | | | | | | | | | | |
| Buttons | |  | | | | | | | | | | | | | | |
| Zips | |  | | | | | | | | | | | | | | |
| Shoe laces | |  | | | | | | | | | | | | | | |
| Cut with scissors | |  | | | | | | | | | | | | | | |
| Write their name | |  | | | | | | | | | | | | | | |
| Apply make-up | |  | | | | | | | | | | | | | | |
| Put on own jewellery or watch | |  | | | | | | | | | | | | | | |
| Use a mobile phone | |  | | | | | | | | | | | | | | |
| Use a computer or games console | |  | | | | | | | | | | | | | | |
| **Physiotherapy**  Please indicate if the applicant can use/do the following and give details of help needed | | | | | | | | | | | | | | | | |
| Steps | |  | | | | | | | | | | | | | | |
| Stairs | |  | | | | | | | | | | | | | | |
| Lifts | |  | | | | | | | | | | | | | | |
| Escalator | |  | | | | | | | | | | | | | | |
| Public transport | |  | | | | | | | | | | | | | | |
| Level of road safety awareness | |  | | | | | | | | | | | | | | |
| Speed of walking | | Slow/fast/average etc. | | | | | | | | | | | | | | |
| Ability to run | |  | | | | | | | | | | | | | | |
| Walking stamina | | Distance/fatigue/motivation etc. | | | | | | | | | | | | | | |
| Ability on slopes or uneven ground | |  | | | | | | | | | | | | | | |
| **Other** | | | | | | | | | | | | | | | | |
| Please list any physical activities regularly practised by the applicant | |  | | | | | | | | | | | | | | |
| Has the applicant had any orthopaedic surgery or monitoring? Please describe with date | |  | | | | | | | | | | | | | | |
| Do you have any concerns about the applicant’s posture? | |  | | | | | | | | | | | | | | |
| Has the applicant had physiotherapy in the past? | |  | | | | | | | | | | | | | | |
| Are there any physiotherapy concerns or issues which could help us? | |  | | | | | | | | | | | | | | |
| **Equipment**  Please give details of equipment the applicant would bring with them to  Young Epilepsy | | | | | | | | | | | | | | | | |
| Wheelchair | |  | | | | | | | | | | | | | | |
| Wheelchair accessories | |  | | | | | | | | | | | | | | |
| Special seating | |  | | | | | | | | | | | | | | |
| Special footwear | |  | | | | | | | | | | | | | | |
| Orthoptics (insoles, splints etc.) | |  | | | | | | | | | | | | | | |
| Head protection | |  | | | | | | | | | | | | | | |
| Protective clothing | |  | | | | | | | | | | | | | | |
| Padding | |  | | | | | | | | | | | | | | |
| Bed (high-low, mattress, guard) | |  | | | | | | | | | | | | | | |
| Hoist or changing bed | |  | | | | | | | | | | | | | | |
| Food preparation equipment | |  | | | | | | | | | | | | | | |
| Electronic voice communication aid | |  | | | | | | | | | | | | | | |
| Communication book or cards | |  | | | | | | | | | | | | | | |
| Other | |  | | | | | | | | | | | | | | |
| **Equipment at Home**  Please give details of any equipment the applicant will not bring with them to  Young Epilepsy | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **Equipment Needed**  Please list any equipment that has been recommended or that you feel the applicant may need but has not been supplied | | | | | | | | | | | | | | | | |
| Equipment type | |  | | | | | | | | | | | | | | |
| Recommended by? | |  | | | | | | | | | | | | | | |
| Equipment type | |  | | | | | | | | | | | | | | |
| Recommended by? | |  | | | | | | | | | | | | | | |
| Equipment type | |  | | | | | | | | | | | | | | |
| Recommended by? | |  | | | | | | | | | | | | | | |
| **Psychology** | | | | | | | | | | | | | | | | |
| Has the applicant been diagnosed with Autism Spectrum Disorders or Asperger’s disorder? | | | | | | | | | | | | | | | | Yes  No |
| If yes, please specify when and by whom. | | | | |  | | | | | | | | | | | |
| Has the applicant been diagnosed with Attention Deficit and Hyperactive Disorder? | | | | | | | | | | | | | | | | Yes  No |
| If yes, please specify when and by whom. | | | | |  | | | | | | | | | | | |
| Has the applicant been diagnosed with Learning Disabilities/Intellectual Disabilities | | | | | | | | | | | | | | | | Yes  No |
| If yes, please specify when and by whom. | | | | |  | | | | | | | | | | | |
| **Mental Health** | | | | | | | | | | | | | | | | |
| Has the applicant been diagnosed with a mental health condition? If yes please specify using the table below. | | | | | | | | | | | | | | | | Yes  No |
| Mental disorders | | | | | Yes | No | When? | | | | | | By whom? | | | |
| Anxiety Disorder | | | | |  |  |  | | | | | |  | | | |
| Depressive Disorder | | | | |  |  |  | | | | | |  | | | |
| Schizophrenia | | | | |  |  |  | | | | | |  | | | |
| Bipolar Disorder | | | | |  |  |  | | | | | |  | | | |
| Communications Disorders | | | | |  |  |  | | | | | |  | | | |
| Rett’s Disorder | | | | |  |  |  | | | | | |  | | | |
| Tourette’s Disorder | | | | |  |  |  | | | | | |  | | | |
| Encopresis | | | | |  |  |  | | | | | |  | | | |
| Enuresis | | | | |  |  |  | | | | | |  | | | |
| Selective Mutism | | | | |  |  |  | | | | | |  | | | |
| Other (please specify | | | | |  | | | | | | | | | | | |
| **Understanding Behaviour** | | | | | | | | | | | | | | | | |
| Does the applicant present with any of the following behaviours? | | | | | | | | | | | | | | | | |
| Behaviour | | | | | Yes | No | Please specify explaining incidents, people involved, circumstances, consequences etc. | | | | | | | | | |
| Physical aggression towards other (eg hits, kicks, bites) or to property (eg throws or breaks furniture) | | | | |  |  |  | | | | | | | | | |
| Antisocial behaviour including bullying (eg taunts, teases or bullies others) | | | | |  |  |  | | | | | | | | | |
| Lacks social awareness (eg over familiarity with strangers) | | | | |  |  |  | | | | | | | | | |
| Overactive or restless | | | | |  |  |  | | | | | | | | | |
| Verbal aggression | | | | |  |  |  | | | | | | | | | |
| Absconding | | | | |  |  |  | | | | | | | | | |
| Sexually inappropriate behaviour (eg exposes self, masturbates in public, improper sexual advances | | | | |  |  |  | | | | | | | | | |
| Self-injury (eg bangs head, hits and bites self, picks skin) | | | | |  |  |  | | | | | | | | | |
| Anger outbursts | | | | |  |  |  | | | | | | | | | |
| Non-compliant or un-cooperative | | | | |  |  |  | | | | | | | | | |
| Other (please specify) | | | | |  | | | | | | | | | | | |
| **Previous/Current Psychological Input** | | | | | | | | | | | | | | | | |
| Is the applicant receiving individual therapy with a psychologists? | | | | | | | | | | | | | | | | Yes  No |
| If yes, please specify the purpose of the intervention | | | | |  | | | | | | | | | | | |
| Have they received individual psychological input in the past? | | | | | | | | | | | | | | | | Yes  No |
| If yes, please specify when and by whom and the purpose of the intervention | | | | |  | | | | | | | | | | | |
| Is the applicant receiving group therapy with a psychologist? | | | | | | | | | | | | | | | | Yes  No |
| If yes, please specify the purpose of the intervention | | | | |  | | | | | | | | | | | |
| Have they received group therapy in the past? | | | | | | | | | | | | | | | | Yes  No |
| If yes, please specify when and by whom and the purpose of the intervention | | | | |  | | | | | | | | | | | |
| Have they received any input regarding their behaviour? | | | | | | | | | | | | | | | | Yes  No |
| If yes, please specify the purpose of the intervention | | | | |  | | | | | | | | | | | |
| Have any behavioural programmes, guidelines or risk assessments been created? | | | | | | | | | | | | | | | | Yes  No |
| If yes, please could you provide us with a copy? | | | | |  | | | | | | | | | | | |
| Is the applicant being regularly reviewed by a psychiatrist? | | | | | | | | | | | | | | | | Yes  No |
| If yes, please specify the purpose of the intervention | | | | |  | | | | | | | | | | | |
| Have they received individual psychiatric input in the past? | | | | | | | | | | | | | | | | Yes  No |
| If yes, please specify when and by whom and the purpose of the intervention | | | | |  | | | | | | | | | | | |
| **Sleeping** | | | | | | | | | | | | | | | | |
| Does the applicant… | | | | | Yes | No | Please give details | | | | | | | | | |
| Sleep in a bed? | | | | |  |  |  | | | | | | | | | |
| Sleep soon after going to bed | | | | |  |  |  | | | | | | | | | |
| Usually sleep through the night? | | | | |  |  |  | | | | | | | | | |
| Require intensive supervision at night? | | | | |  |  |  | | | | | | | | | |
| What time do they go to bed? | | | | |  | | | | | | | | | | | |
| What time do they usually wake up? | | | | |  | | | | | | | | | | | |
| Please give details of any sleep disturbances | | | | |  | | | | | | | | | | | |
| Please give details of any night time seizures | | | | |  | | | | | | | | | | | |
| **Continence** | | | | | | | | | | | | | | | | |
| Does the applicant… | | | | | Yes | No | Please give details | | | | | | | | | |
| Use the toilet independently day and night? | | | | |  |  |  | | | | | | | | | |
| Have a catheter, colostomy or anything else needing specialist care? | | | | |  |  |  | | | | | | | | | |
| Indicate the need for the toilet? | | | | |  |  |  | | | | | | | | | |
| Sit on the toilet? | | | | |  |  |  | | | | | | | | | |
| Need incontinence pads during the day? | | | | |  |  |  | | | | | | | | | |
| Need incontinence pads at night? | | | | |  |  |  | | | | | | | | | |
| Need toileting at night? | | | | |  |  |  | | | | | | | | | |
| Please give any other details that may help with toileting | | | | |  | | | | | | | | | | | |
| **Respite Services** | | | | | | | | | | | | | | | | |
| Have Respite Services ever been involved with the applicant? | | | | |  | | | | | | | | | | | |
| How often do they have respite? | | | | |  | | | | | | | | | | | |
| Name of Respite Service | | | | |  | | | | | | | | | | | |
| Address | | | | |  | | | | | | | | | | | |
| Postcode | | | | |  | | | | | | | | | | | |
| Telephone | | | | |  | | | | | | | | | | | |
| Details of involvement | | | | |  | | | | | | | | | | | |
| **Social Services** | | | | | | | | | | | | | | | | |
| Have Social Services ever been involved with the applicant? | | | | |  | | | | | | | | | | | |
| Name of Social Worker | | | | |  | | | | | | | | | | | |
| Address | | | | |  | | | | | | | | | | | |
| Postcode | | | | |  | | | | | | | | | | | |
| Telephone | | | | |  | | | | | | | | | | | |
| Details of involvement | | | | |  | | | | | | | | | | | |
| **Expectations** | | | | | | | | | | | | | | | | |
| Why is a placement at Young Epilepsy required? | | | | |  | | | | | | | | | | | |
| What are the expectations of Young Epilepsy from the Parent or Carer? | | | | |  | | | | | | | | | | | |
| What are the expectations of Young Epilepsy from the Applicant? | | | | |  | | | | | | | | | | | |
| Any other relevant information which may be helpful during the assessment period? | | | | |  | | | | | | | | | | | |
| What other providers have you applied to? | | | | |  | | | | | | | | | | | |
| **Signatures – Information on this form is provided by:** | | | | | | | | | | | | | | | | |
| Name(s) | | | | |  | | | | | | | | | | | |
| Relationship to student | | | | |  | | | | | | | | | | | |
| Signature 1 | | | | |  | | | | | | | | | | | |
| Date | | | | |  | | | | | | | | | | | |
| Signature 2 (if applicable) | | | | |  | | | | | | | | | | | |
| Date | | | | |  | | | | | | | | | | | |
| **Young Epilepsy has a policy to adhere to the 1998 Data Protection Act. The information we are asking you for may be placed in a manual file, placed on a computer database and passed to other individuals both internally and externally who are involved with the student. By signing and completing this form you are agreeing to the above statement. If you do not agree to any aspect of this please indicate below.** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |



Please return **WITH YOUR ECHP** to: Education Liaison Service, St Piers School & College, St Piers Lane, Lingfield, Surrey RH7 6PW. Email: [education@youngepilepsy.org.uk](mailto:education@youngepilepsy.org.uk) Tel: 01342 832243



**Parental Consent for Reports**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Applicant’s Name | |  | | |
| Address | |  | | |
| Postcode | |  | | |
| Date of Birth | |  | | |
| NHS Number | |  | | |
| Unique Learner Number | |  | | |
| **Consultant** | | | **Neurologist** | |
| Name |  | | Name |  |
| Address |  | | Address |  |
| Postcode |  | | Postcode |  |
| Phone |  | | Phone |  |
| **Psychiatrist** | | | **GP** | |
| Name |  | | Name |  |
| Address |  | | Address |  |
| Postcode |  | | Postcode |  |
| Phone |  | | Phone |  |
| **Psychologist (including educational)** | | | **Social Worker** | |
| Name |  | | Name |  |
| Address |  | | Address |  |
| Postcode |  | | Postcode |  |
| Phone |  | | Phone |  |
| **CAMHS** | | | **Therapist** | |
| Name |  | | Name |  |
| Address |  | | Address |  |
| Postcode |  | | Postcode |  |
| Phone |  | | Phone |  |
| **Surgeon (Neuro/Orthopaedic/Other)** | | | **Respite Care** | |
| Name |  | | Name |  |
| Address |  | | Address |  |
| Postcode |  | | Postcode |  |
| Phone |  | | Phone |  |
| **Current or most recent education provider** | | | **As we may need to seek information from the professionals involved in the care of the applicant we would be grateful if you and your young person could confirm below that you give your permission for us to do so.**  **Where appropriate please ask the learner to sign this form, with assistance if necessary.** | |
| Name |  | |
| Address |  | |
| Postcode |  | |
| Phone |  | |
| Name | |  | | |
| Relationship to student | |  | | |
| Parent/Guardian signature | |  | | |
| Date | |  | | |
| Learner signature | |  | | |
| Date | |  | | |

Please return **WITH YOUR ECHP** to: Education Liaison Service, St Piers School & College, St Piers Lane, Lingfield, Surrey RH7 6PW. Email: [education@youngepilepsy.org.uk](mailto:education@youngepilepsy.org.uk) Tel: 01342 832243