Summer Activities 2021

‘All About Me’

Application Form

This Referral Form is to help the staff at KIDS to understand you and learn about what you like, dislike and what sort of help you may need.

Hello, my name is: ……

My birthday is on: …… **I am** ……. **years old**

Please provide a photo to stick here

Please provide or stick a photo here

My address is

……..……

……Post code…….

My Family

My Parents /Carers are called:

1. Name ……Relationship……..

   Phone number..…… Mobile …….

2. Name ……Relationship……..

   Phone number..…… Mobile …….

3. Name ……Relationship……..

   Phone number..…… Mobile …….

Email: ……

Other people who might collect me or drop me off are:

Name: ……Relationship:……..

Phone number:..…… Mobile:.…….

In an emergency contact:

Name: ……. Relationship:……..

Telephone number is: ……

Important Information you need to know:

The School I attend is:……

I have an EHC Plan Yes No (Please circle which one)

I am a Looked After Child Yes No

I have a Care Plan Yes No

I have an Epilepsy Plan Yes No

I have a diagnosis for:……

……...

My cultural/ religious background is:……..

What languages I/my family speak:……

My GP (doctor) is called:……

Phone number:……

Important information about me!

I have a condition/s called:……

……

……

Mobility

I use a wheelchair…….. Yes No
I use a wheelchair all the time…….. Yes No
I use a wheelchair when I get tired…….. Yes No
I use a mobility frame……..... Yes No
I use a buggy…….. Yes No

I move around indoors by:…….

……....

I move around outdoors by:……..

……...

I need support when I am near roads or crossing roads Yes No

The best way to keep me safe is to…….....

……...

I feel safe travelling on a mini-bus or in a car Yes No

I need to use a bolster seat Yes No

I need to wear a harness when travelling in a car/mini bus Yes No

I need help getting on/off a mini-bus or in/out of car Yes No

I can become travel sick Yes No

It is ok to lift or carry me if I am told what is happening Yes No

Sometimes I need extra help when I am travelling you can help me by

……..

……..

Personal Care

I need help washing my hands after going to the toilet Yes No

I need help washing my hands before eating Yes No

I need help getting dressed and undressed Yes No

I need help going to the toilet and changing my pads Yes No

I have periods Yes No

Sometimes I also need help with personal care this can be……

……..

……..

……..

Eating and Drinking

I need someone to help with eating and drinking Yes No

I need you to help me.....

……..

……..

I need to be tube-fed Yes No

I do not like to eat……...

……...

I like to eat……

……...

I am allergic to……

……...

I am allergic to nuts Yes No

I like the texture of my food to be……

……...

I like the temperature of my food to be……

……...

I eat using (spoon, fork, built up dish, special cup, other)……

……...

I do not eat or drink orally /or in addition to my diet I have a gastrostomy, NG tube /or I require dietary supplements:

(Please tell us your consultant's name and or nurse so that we can ask them more and arrange training and a health care plan. This is so people required to give emergency medication have been trained)

Consultants name…….. Tel:.....

Nurse's name…….. Tel:.....

I am not allowed to have any of the following foods/drinks:

……

……

This is what happens if I do……

……

……

To help me you need to……

……

……

Communication

I will communicate by	Talking	Yes	No
	Makaton	Yes	No
	PECS	Yes	No
	Pointing	Yes	No
	Showing	Yes	No

I may also communicate with by……..

……

……

Please speak to me like this:……

……

……..

Please approach me like this……

……....

……...

This is how I tell you I'm happy:……..

……

……..

Some things that make me happy are:……..

……

……..

This is how I tell you I'm frightened or anxious:…….....

……

……..

Things that make me frightened or anxious are:……..

……

……..

This is how I tell you I'm upset or cross:…….

……

……..

This is how I will let you know that I'm hungry or thirsty:……..

……..……

……..…..

This is how I will let you know I'm not well or in pain:

……..……

……..….

This is how I will let you know I want to go to the toilet or I need my pad changing

……..……

Behaviour

Sometimes I may self-harm Yes No

Things that make me agitated are……...

……...

……...

Sometimes I may have challenging behaviour and I will…….

……..

……..

……..

When I become upset and go into crises I need you to……...

……...

……...

……...

Other

I have a hearing impairment Yes No

This is how you can help me……

……...

……..

I am visually impaired Yes No

This is how you can help me……

……...

……..

I am technology dependent Yes No

This is how you can help me……

……..

……

Medication

I take medication Yes No

This is what I take:

Name of medication……Dosage ……Time…… by syringe spoon other

Name of medication……Dosage ……Time…… by syringe spoon other

Name of medication……Dosage ……Time…… by syringe spoon other

Name of medication……Dosage……..Time…… by syringe spoon other

I also take emergency medication for…….

……..

The medication is called……

This is how I take it……

I am allergic to……

This is what happens if I have a reaction: ……

……

I need you to do this if this happens:

……

……

……

(Please tell us your consultant's name and or nurse so that we can ask them more and arrange training and a health care plan. This is so people required to give emergency medication have been trained)

Consultants Name…… Tel:.....

Nurse's Name…… Tel:.....

Enjoying Myself



My favourite toys, games, activities and interests are:……..

…….

…….

To take part in activities I need help with:……

…….

…….

These are some things that I really don't like:…….

…….

…….

…….

Feeling Safe

The staff will need to have the following training: (e.g. equipment, emergency medication etc.) to keep me safe:

…….

…….

…….

…….

This is how I will let you know I'm not well or in pain:……..

……..……

……

<u>Other thing's I would like you to know:</u>

Contacts

People you might need to contact about training and or equipment I might require (Therapist, Social Worker, Children's Community Nurse, School etc.)

Name	Tel:	Who they are

Consent by young person

- Please circle as appropriate

I agree to KIDS storing my personal information YES/NO
I agree that in an emergency KIDS will take appropriate action YES/NO
(must be YES if no parent/carer will be present)
I agree to KIDS sharing my personal information with other professionals YES/NO
I agree to KIDS to taking and using photographs and/or video of me for publicity YES/NO
I agree to KIDS staff administering medication/medical procedures to me YES/NO
I agree to KIDS staff providing personal care to me YES/NO
I agree to having my face paints being used on my skin YES/NO
I agree to keeping KIDS informed of any changes to the information on this form YES/NO

Signature of child or young person aged 12 or above

…… Date……

Consent by Parent/s or Carer/s

- Please circle as appropriate

I agree to KIDS storing my child's personal information YES/NO
I agree that in an emergency KIDS will take appropriate action YES/NO
(must be YES if no parent/carer will be present)
I agree to KIDS sharing my child's personal information with other professionals YES/NO
I agree to KIDS taking and using photographs and/or video of my child for publicity YES/NO
I agree to KIDS staff administering medication/medical procedures to my child YES/NO
I agree to KIDS staff providing personal care to my child YES/NO
I agree to KIDS staff applying sun cream to my child YES/NO
I agree to my child having face paints used on their skin YES/NO
I agree to keeping KIDS informed of any changes to the information on this form YES/NO

Signature of parent or carer of child

…… Date……