**Application Form**

Click or tap here to enter text.

**Student Name:**

**Placement Commencing:**( 2024 / 2025 / 2026 )

Click or tap here to enter text.

**Please ensure that this form is fully completed before it is returned. In addition, it is very important that St Piers is in receipt of the reports listed below. Please be aware that without these, we will be unable to progress your application**.

Please indicate which reports are attached:

Current EHCP  Latest Annual Review  Behaviour Support Plan

Latest School Report  Medical Reports  Therapy Reports

Respite Report (if applicable)  Other

If other please specify:

Click or tap here to enter text.

Please tell us where you heard about us:

Local Authority

Local Offer

Website

Natspec

Applicant’s current school

Facebook

Recommendation

Other (please specify):

Click or tap here to enter text.

Have you been to a virtual open day? Yes  No

Have you visited St Piers? Yes  No

Return all information to:

Admissions, St Piers School and College,

Young Epilepsy, St Piers Lane, Lingfield, Surrey, RH7 6PW

or [education@youngepilepsy.org.uk](mailto:education@youngepilepsy.org.uk)

**Section 1 – About the applicant**

*[****Attach passport-sized photo here]***

|  |  |
| --- | --- |
| Student’s full name |  |
| Student’s address |  |
| Student’s postcode |  |
| Local authority |  |
| Gender | Male  Female  Other  Please specify: |
| Date of birth |  |
| Nationality |  |
| Home language |  |
| Religion |  |
| Unique Learner Number |  |
| NHS Number |  |
|  |  |
| **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  2022  2023  2024  2025 | | SCHOOL 5-16  SIXTH FORM 16-19 YRS  COLLEGE 19-25 YRS  Placement Type:  Day  Weekly boarding (Monday 9am – Friday 4pm, boarding)  Termly boarding (Monday – Sunday, term-time only) – **Over 18 only** | | |

|  |  |  |  |
| --- | --- | --- | --- |
| What is the student’s primary need? | | Moderate Learning Difficulty (MLD)  Severe Learning Difficulty (SLD)  Profound and Multiple Learning Difficulty (PMLD) | |
| Does the student have Epilepsy? | | Yes  No | |
| What is the student’s diagnosis? | |  | |
|  | |
|  | |
|  | |
|  | |
| Please tick any that apply to the student: | | Social, Emotional & Mental Health  Speech, Language & Communication Needs  Hearing Impairment  Visual Impairment  Multi-Sensory Impairment  Physical Disability  Autistic Spectrum Disorder  SEN support but no specialist assessment of type of need  Sensory processing difficulties  Other Difficulty/ Disability  If other, please state: | |
| **Safeguarding** | | | |
| Have there been any safeguarding or child/adult protection concerns related to this child/young person?  Yes  No  If yes, please provide dates and details: | | | |
| Is the child currently on a child protection plan or have they been on a child protection plan? Yes  No  If yes, please explain why: | | | |
| Is the child a Child in Need? Yes  No | | | |
| Have the police ever been called in relation to this child/young person?  Yes  No  If yes, please provide dates and details: | | | |
| Is the young person a Child Looked After/Looked After Child, being looked after by the local authority?  Yes  No | | | If ‘Yes’ is it: Involuntarily through a Care Order (Section 31)  Voluntarily under section 20 or 85 |
| Is the young person a care leaver? This applies to young people over the age of 18 years if they were Child Looked After/Looked After Child when they were under 18.Yes  No | | | |
| **PARENTAL RESPONSIBILITY: In accordance with The Children Act 1989 (under 18’s) please give full details below of ALL persons with parental responsibility and to whom correspondence, reports invitations etc. should be sent.** | | | |
| **Social Services** | | | |
| Does the applicant have a Social Worker? | Yes  No | | |
| Name of Social Worker |  | | |
| Address |  | | |
| Postcode |  | | |
| Telephone |  | | |
| Details of involvement |  | | |
| Parent/Carer 1 | | | |
| Name | | |  |
| Relationship to student | | |  |
| Address | | |  |
| Postcode | | |  |
| Telephone – Home | | |  |
| Telephone – Mobile | | |  |
| Email | | |  |
| Parent/Carer 2 | | | |
| Name | | |  |
| Relationship to student | | |  |
| Address | | |  |
| Postcode | | |  |
| Telephone – Home | | |  |
| Telephone – Mobile | | |  |
| Email | | |  |
| Deputy/Local Authority Contact Information | | | |
| Does anyone have deputyship for Personal Welfare  Property & Affairs | | | |
| If yes, who is the appointed deputy *(Please include a copy of the Court Order appointing the Deputy)* | | |  |
| Local Authority contact name | | |  |
| Local Authority contact address | | |  |
| Postcode | | |  |
| Local Authority contact email address | | |  |
| **Section 2 - Education Information** | | | |

|  |  |
| --- | --- |
| Is the applicant Currently in School? Yes  No  If no, when was the last date the applicant was in education? | |
| If the student is currently not in education, please advise why and detail what activities they are taking part in day to day. |  |

|  |  |
| --- | --- |
| 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** |  |

|  |  |
| --- | --- |
| Has the student ever been a school refuser? Please give details. |  |
| Has the student ever been refused admission to or excluded from a school or college? Please provide details. |  |
| Please provide details of current educational levels achieved | Literacy  Numeracy  Science  Other |
| What level of qualification does the student have? Please give details. |  |
| Does the student have access to the National Curriculum or does the student have a modified curriculum? Please give details. |  |
| Does the student receive additional support in the classroom? If so, for how long? Why is additional support required? |  |
| What specific interests does the student have at school/college and what motivates them to learn? Is there anything that they do not like? |  |
| Leisure/hobbies/clubs/interests outside of school/college |  |
| Religious or cultural needs |  |

|  |  |
| --- | --- |
| **Section 3 – Respite Services** | |
| Have Respite Services ever been involved with the student? |  |
| How often do they have respite? |  |
| Last date at respite? |  |
| Name of Respite Service |  |
| Address |  |
| Postcode |  |
| Telephone |  |
| Details of involvement |  |

|  |
| --- |
| **Section 4 – Medical Information** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| What is the applicant’s medical diagnosis? | | | | |  | | | | | | | | | | | | | |
| **Section 5 – Epilepsy Information**  **(*If applicant does not have epilepsy go to section 6)*** | | | | | | | | | | | | | | | | | | |
| Does the applicant have seizures? | | | | | Yes  No | | | | | | If yes, please describe how we would recognise different seizure types and duration : | | | | | | | |
| Has a seizure ever lasted longer than 30 minutes? | | | | | Yes  No | | | | | | If yes, what was the treatment given ? | | | | | | | |
| 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?  Did they experience any adverse reaction to this: | | | | | Yes  No  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: | | | | | | | |
| **Section 6 - Current Medication** | | | | | | | | | | | | | | | | | | |
| Routine Drug(s) (Name) | | | | Strength | | | | | | Dosage | | Times given and how administered | | | | | | |
|  | | | |  | | | | | |  | |  | | | | | | |
| Emergency Drug(s) Name  *(please provide a copy of the current epilepsy care plan if you have one)* | | | | Strength | | | | | | Dosage | | When and how administered | | | | | | |
|  | | | |  | | | | | |  | |  | | | | | | |
| Has the applicant ever had an adverse reaction to any medication | | | | Yes | | | No | | | Details: | | | | | | | | |
| Does the applicant experience or require treatment for any of the following? | | | | Yes | | | No | | | Details: | | | | | | | | |
| Diabetes | | | |  | | |  | | |  | | | | | | | | |
| Asthma | | | |  | | |  | | |  | | | | | | | | |
| Eczema | | | |  | | |  | | |  | | | | | | | | |
| Heart Problems | | | |  | | |  | | |  | | | | | | | | |
| Bowel/Bladder Problems | | | |  | | |  | | |  | | | | | | | | |
| Orthopaedic 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 |  |  |  | | | | | |  | | | | | | | | | |
|  | | | | |  | | | | | | | | | | | | | |
| Does the applicant have epilepsy or other types of seizures? If yes, please describe. | | | | |  | | | | | | | | | | | | | |
| **IMPORTANT**  **Please provide the contact details of professionals involved in the applicant’s medical care in Section 9 – Consents which is at the end of this application form.** | | | | | | | | | | | | | | | | | | |
| **Section 7 – Mental Health** | | | | | | | | | | | | | | | | | | |
| Has the student 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 | | | |  | |  | |  | | | | | |  | | | | |
| Selective Mutism | | | |  | |  | |  | | | | | |  | | | | |
| Other (please specify) | | | |  | | | | | | | | | | | | | | |
| **Previous/Current Psychological Input** | | | | | | | | | | | | | | | | | | |
| Is the student receiving individual or group therapy with a psychologist? | | | | | | | | | | | | | | | | | Yes  No | |
| If yes, please specify the purpose of the intervention | | | |  | | | | | | | | | | | | | | |
| Have they received individual or group psychological input 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 provide us with a copy? What changes occurred after the intervention? | | | |  | | | | | | | | | | | | | | |
| Is the student 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 | | | |  | | | | | | | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Section 8 – Understanding Behaviour** | | | | | |
| To help us understand more about the applicant please let us know if they present with any of the following behaviours? | | | | | |
| Behaviour | | Yes | No | Please specify explaining incidents, people involved, circumstances and outcomes | |
| Physical aggression towards other (e.g. hits, kicks, bites) or to property (e.g. throws or breaks furniture) | |  |  | Please specify frequency and nature of incidents | |
| Date of last incident | |
| Antisocial behaviour including bullying (e.g. taunts, teases or bullies others) | |  |  | Please specify frequency and nature of incidents | |
| Date of last incident | |
| Lacks social awareness (e.g. over familiarity with strangers) | |  |  | Please specify frequency and nature of incidents | |
| Date of last incident | |
| Overactive or restless | |  |  | Please specify frequency and nature of incidents | |
| Date of last incident | |
| Verbal aggression | |  |  | Please specify frequency and nature of incidents | |
| Date of last incident | |
| Run off or go missing | |  |  | Please specify frequency and nature of incidents | |
| Date of last incident | |
| Sexually inappropriate behaviour (e.g. exposes self, masturbates in public, improper sexual advances | |  |  | Please specify frequency and nature of incidents | |
| Date of last incident | |
| Self-injury (e.g. bangs head, hits and bites self, picks skin) | |  |  | Please specify frequency and nature of incidents | |
| Date of last incident | |
| Anger outbursts | |  |  | Please specify frequency and nature of incidents | |
| Date of last incident | |
| Non-compliant or un-cooperative | |  |  | Please specify frequency and nature of incidents | |
| Date of last incident | |
| Other (please specify) | |  | | | |
| **Section 9 - Health and Wellbeing** | | | | | |
| To help us to understand more about the applicant | | | | | |
| **Sleeping** | | | | | |
| Does the student… | | 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 student… | | 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 | |  | | | |
| If student suffers from incontinence, do they have products provided by incontinence service? If they do not, they will need to apply to their local incontinence team for assessment. Yes  No | | | | | |
| **Therapy:****Occupational, Speech and Language and Physiotherapy** | | | | | |
|  | | | | | |
| Does the applicant see a therapist at their current school or at home? | | | | | Yes  No  SLT  OT  Physiotherapy  Where does the therapist see the student? |
| Do you know what they do? If so, please give details | | | | |  |
| Does the applicant experience any visual difficulties? If yes, please give details | | | | |  |
| Has the student attended any ophthamology or orthoptic appointments? If so, please summarise where, when and what for. | | | | |  |
| Does the applicant have input from a visual advisory team and/or visual advisory teacher? If yes, please state when and where. | | | | |  |
| **Communication** | | | | | |
| How would you describe the student’s ability to communicate with people? Do they use verbal communication, symbols, PECS, electronic devices, or sign language? | | | | |  |
| What do you see as their strong points in communicating? | | | | |  |
| Please describe any concerns about their communication or areas of communication that are of concern to you. | | | | |  |
| **Oral Skills and Hearing** | | | | | |
| Can the student chew and swallow effectively? | | | | |  |
| Have they been known to cough or choke on food or drink? | | | | | Never  Occasionally  Regularly |
| Have they ever had chest infections related to eating or drinking? | | | | |  |
| Are there any foods you would not give them because of the texture? | | | | |  |
| Does the student need any support with eating or drinking? (e.g. food cut into small pieces/pacing) | | | | |  |
| Have they been seen by an SLT or ever has recommendations around eating and drinking? | | | | |  |
| Have they ever needed tube feeding? | | | | |  |
| Do they experience any hearing problems? Please describe any concerns. | | | | |  |
| When the last known hearing test and what was the result? | | | | |  |
| Has the student attended ENT or Audiology at any hospital? Please say where or when. | | | | |  |
| **Personal Care**  Please give details of the applicant’s ability including any support needed and equipment used | | | | | |
| Washing |  | | | | |
| Dressing |  | | | | |
| If they wear a pad, are they changed | Lying down  Standing | | | | |
| Which is preferred | Shower  Bath | | | | |
| Grooming (hair, nails, teeth) |  | | | | |
| Facial hair removal |  | | | | |
| Body hair removal |  | | | | |
| Managing Periods |  | | | | |
| **Safety and Activities**  Can the student do the following? Please give details. | | | | | |
| Use a mobile phone |  | | | | |
| Use a computer or games console |  | | | | |
| Cross the road independently |  | | | | |
| Access public transport |  | | | | |
| Do they wear a protective helmet? |  | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Mobility**  Please indicate if the student can use/do the following and give details of help needed | | | | |
| Steps |  | | | |
| Stairs |  | | | |
| Lifts |  | | | |
| Escalator |  | | | |
| Speed of walking | Slow  Average  Fast | | | |
| Ability to run |  | | | |
| Walking stamina | Poor  Average  Excellent | | | |
| Ability on slopes or uneven ground |  | | | |
| **Physiotherapy** | | | | |
| Has the applicant had any orthopaedic surgery? If yes, please state what surgery, what was the outcome and when. |  | | | |
| Does the applicant have any orthopaedic monitoring? If yes, when, where and do you expect this will continue if they attend Young Epilepsy? |  | | | |
| **Equipment**  Please give details, where known, of specialist equipment that the applicant benefits from using | | | | |
| **Equipment** | **Make** | | **Model** | **What it helps with** |
| Bed |  | |  |  |
| Shower Chair |  | |  |  |
| Bath Lift |  | |  |  |
| Changing Table |  | |  |  |
| Hoist |  | |  |  |
| Sling |  | |  |  |
| Wheelchair |  | |  |  |
| Seating - Dining |  | |  |  |
| Seating - Education |  | |  |  |
| Seating - Leisure |  | |  |  |
| Splints | Wrist/Hand | | Foot | Other |
| Specialist Footwear | Yes  No  if yes, please state style: | | | |
| Helmet | Yes  No  If yes, please state style: | | | |
| Protective clothing | Yes  No  If yes, please state type: | | | |
| Environmental padding | Yes  No  If yes, please state type and location: | | | |
| Communication book or cards | Yes  No  If yes, please state type: | | | |
| Electronic voice communication aid | Yes  No  If yes, please state type: | | | |
| Any other equipment? |  | | | |
| **Section 10 - Expectations and Aspirations** | | | | |
| Why is a placement at Young Epilepsy required? | |  | | |
| What expectations does the parent or carer have of Young Epilepsy? | |  | | |
| What are the aspirations of the student? This could include where they would like to live, activities they like and if they would like voluntary or paid employment. | |  | | |
| As a family, what are your future plans/goals for the student? | |  | | |
| Any other relevant information which may be helpful during the assessment period? | |  | | |
| What other providers have you applied to? | |  | | |
| Is St Piers School and College your first choice?  If not, please state your preference: | |  | | |
| **Section 11 – Signatures and Consents** | | | | |
|  | | | | |
| **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.** | | | | |
|  | | | | |

**Consent for Reports**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Student’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 |  |
| **We may wish to contact the individuals and organisations that have been identified in this form to obtain reports and other information from them and need consent to be able to do so. The type of consent needed will vary depending on the student’s age and capacity under the Mental Capacity Act:**   * **Parental Consent – If the student is under 16** * **Deputy Consent – If the student lacks the capacity to make this decision and has a Personal Welfare Deputy** * **Student Consent – If the student is over 16 and has the capacity to make this decision** * **Supporting best interest decision by parents – if the student is over 16 and lacks capacity to make this decision**   **We would be grateful if you and your young person could confirm below that you give your permission for us to contact individuals and organisations identified, if necessary. Please indicate which type of consent applies and where appropriate, ask the learner to sign this form.** | | | | |
| Consent Type | | Parental Consent  Deputy Consent  Student Consent  Supporting best interest decision by Parents | | |
| Name | |  | | |
| Relationship to student | |  | | |
| Parent/Guardian signature | |  | | |
| Date | |  | | |
| Learner signature | |  | | |
| Date | |  | | |