# St Piers
# School and Sixth Form and FE College

# Application Form

**Applicant Name:**

**Placement Commencing:**
(2020 / 2021 / 2022)

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:

Return all information to:

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

or education@youngepilepsy.org.uk

# About the applicant

| | | |
|---|---|---|
| Applicant's full name | | |
| Applicant's address | | |
| Applicant's postcode | | ***[Attach passport-sized photo here]*** |
| Local authority | | |
| Gender | ☐ Male ☐ Female | |
| 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<br>☐Irish<br>☐Other<br>Please specify: | ☐White/Black Caribbean<br>☐White/Black African<br>☐White/Asian<br>☐Other<br>Please specify: | ☐Indian<br>☐Pakistani<br>☐Bangladeshi<br>☐Other<br>Please specify: | ☐Caribbean<br>☐African<br>☐Other<br>Please specify: | ☐Chinese<br>☐Other<br>Please specify: |

| | |
|---|---|
| Placement commencing<br>2020 ☐ 2021 ☐<br>2022 ☐ 2023 ☐ | ☐ SCHOOL 5-16<br>☐ SIXTH FORM 16-19 YRS<br>☐ COLLEGE 19-25 YRS<br><br>Placement Type:<br>☐ Day<br>☐ Weekly (Monday 9am – Friday 4pm, boarding)<br>☐ Termly (Monday – Sunday, term-time only) |
| What is the applicant's primary need? | ☐ Moderate Learning Difficulty (MLD)<br>☐ Severe Learning Difficulty (SLD)<br>☐ Profound and Multiple Learning Difficulty (PMLD) |
| Does the applicant have Epilepsy? | ☐ Yes<br>☐ No |
| What is the applicant's diagnosis? | |
| Please tick any that apply to the applicant: | ☐ Social, Emotional & Mental Health<br>☐ Speech, Language & Communication Needs<br>☐ Hearing Impairment<br>☐ Visual Impairment<br>☐ Multi-Sensory Impairment<br>☐ Physical Disability<br>☐ Autistic Spectrum Disorder<br>☐ SEN support but no specialist assessment of type of need<br>☐ Other Difficulty/ Disability<br>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 details:

Is the child currently on a child protection plan or have they been on a child protection plan?
Yes ☐ No ☐

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 details:

| | |
|---|---|
| Is the young person looked after by local authority?<br>Yes ☐ No ☐ | If 'Yes' is it:<br>Involuntarily through a Care Order (Section 31) ☐<br>Voluntarily under section 20 or 85 ☐ |

Is the young person a care leaver? 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.**

## Parent/Carer 1

| | |
|---|---|
| Name | |
| Relationship to applicant | |
| Address | |
| Postcode | |
| Telephone – Home | |
| Telephone – Mobile | |
| Email | |

| Parent/Carer 2 | |
|---|---|
| Name | |
| Relationship to applicant | |
| 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 | |

| Deputy/Local Authority Contact Information (Cont) | |
|---|---|
| Local Authority contact address | |
| Postcode | |
| Local Authority 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** | |

| | |
|---|---|
| Please provide details of current educational levels achieved | Literacy<br>Numeracy<br>Science<br>Other |
| Does the applicant receive additional support in the classroom? If so, for how long? | |
| What specific interests does the applicant have at school/college? Is there anything that they do not like? | |
| Does the applicant have access to the National Curriculum? | |
| What level of qualification does the applicant have? | |
| Does the applicant have a modified curriculum? Please give details. | |
| Has the applicant ever been refused admission to a school or college? Please provide details. | |

| | |
|---|---|
| Has the applicant ever been excluded from a school or college? Please provide details. | |
| If the applicant is currently not in education please advise why and details what activities they are taking part in day to day. | |

## Other

| | |
|---|---|
| Does the applicant have access to a psychologist? Please advise input received: | |
| Leisure/hobbies/clubs/interests | |
| Religious or cultural needs | |

## Medical Information

| | | | |
|---|---|---|---|
| Does the applicant have seizures? | Yes ☐ No ☐ | If yes, please detail 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?<br><br>Did they experience any adverse reaction to this: | Yes ☐ No ☐<br><br>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 |

| | | | | |
|---|---|---|---|---|
| | | | | |
| Has the applicant ever had an adverse reaction to any of these medications | Yes | No | Details: | |
| Does the applicant experience 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 |
|---|---|---|---|
| Does the applicant have eyesight problems? | ☐ | ☐ | ☐ |
| If yes, is the applicant registered blind? | ☐ | ☐ | ☐ |
| Does the applicant have hearing problems? | ☐ | ☐ | ☐ |

Please provide further details:

## 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, and objects of reference, PECS, electronic communication aids or a communication book? Please specify. | |

| Oral Skills and Hearing | |
|---|---|
| Can the applicant chew and swallow effectively? | |
| Have they been known to cough or choke on food or drink? | ☐ Never<br>☐ Occasionally<br>☐ 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 applicant 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 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 (e.g. 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 state 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**<br>Can the applicant get on/off or in/out of the following? Please give details | |
| Bed | |
| Chair | |
| Toilet | |
| Floor | |
| Bath | |
| **Manual Dexterity**<br>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**<br>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 | |
| Orthotics (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 | ☐ | ☐ | | |
| 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 (e.g. hits, kicks, bites) or to property (e.g. throws or breaks furniture) | ☐ | ☐ | |
| Antisocial behaviour including bullying (e.g. taunts, teases or bullies others) | ☐ | ☐ | |
| Lacks social awareness (e.g. over familiarity with strangers) | ☐ | ☐ | |

| | | | |
|---|---|---|---|
| Overactive or restless | ☐ | ☐ | |
| Verbal aggression | ☐ | ☐ | |
| Run off or go missing | ☐ | ☐ | |
| Sexually inappropriate behaviour (e.g. exposes self, masturbates in public, improper sexual advances | ☐ | ☐ | |
| Self-injury (e.g. 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 | | | |

| |
|---|
| If applicant 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 ☐ |

| 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 expectations does the parent or carer have of Young Epilepsy? | |
| What expectations does the applicant have of Young Epilepsy? | |
| As a family, what are your future plans/goals for the applicant? | |
| 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?<br>If not, please state your preference: | |

## 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

| | |
|---|---|
| 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 | | |
|---|---|---|
| Name | | |
| Address | | |
| Postcode | | Phone |

**Please send us copies of any recent / relevant medical correspondence you have for this applicant**

**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<br>☐ Student Consent ☐ Supporting best interest decision by Parents |
| Name | |
| Relationship to student | |

| | |
|---|---|
| Parent/Guardian signature | |
| Date | |
| Learner signature | |
| Date | |