## St. Elizabeth’s College

Much Hadham

Hertfordshire

SG10 6EW

Tel: 01279 843451

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[www.stelizabeths.org.uk](http://www.stelizabeths.org.uk)



## PLEASE COMPLETE IN CAPITAL LETTERS USING BLACK INK AND RETURN TO Charlotte Sear AT THE ABOVE ADDRESS

**Personal**

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| **St Elizabeth’s College Application/Initial Assessment Information** |
| **Name:** |  | **I like to be known as:** |  |
| **DOB:** |  | **Service/s required** | Day learner □ Residential □  |
| **Current Address:** |  | **Requested start date** **of College placement:** | Month……………………. Year ………….. |
|  |  | **Contact No:** |  |
|  |  | **Mobile:** |  |
|  |  | **National Ins. No:** |  |
|  |  | **Ethnicity:** |  |
|  |  | **Nationality:** |  |
|  |  | **Is St. Elizabeth’s College your first choice?** | **Please Circle:**  **Yes No** |

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| **Are you subject to a Home Office deportation order?** | **Please Circle: Yes No** |
| **Are you able to provide proof of eligibility for funding purposes, for example EU Passport?** | **Please Circle: Yes No** |

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| **Full address of Next of Kin (if different from above)** |  | **Next of Kin Name/s:** |  |
|  | **Home Tel. No:** |  |
| **Mobile No.:** |  |
| **E-mail Address:** |  |

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| **Cultural / Spiritual Needs:** |
| **I have a specific faith and/or belief** |  **Yes / No** |
| **If Yes, please state which faith group you belong to:** |  |
| I like to attend services in relation to my faith / beliefs |  **Yes / No** |
| Please tell us what you would like to attend and any support you may need to assist.  |  |
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| I have special days in the year that I wish to celebrate ( please describe) |  |
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| My first language is English |  **Yes / No** |
| I speak or understand other languages |  **Yes / No** |
| If **Yes,** please tell us of otherlanguages you speak or understand  |  |
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| **Funding Authority: (social services/PCT, joint funded, private etc:** |  |
| **Named contact person & address:** |  |
| **Telephone No:** |  | **E-mail address:** |  |
| **Name of SEN/LA rep if different from above:** |  | **E-mail address:** |  |

**Education**

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| **I have an Education, Health and Care Plan (EHCP)** | **Yes / No** |
| **If no, please provide details of the plan(s) you currently have:** |
| **Current/most recent learning provider, for example School or College:** |  |
| **Address:** |  | **Contact No:** |  |
|  | **E-mail Address:** |  |
| **Please list the details of learning you have undertaken and any qualifications you are working towards or have achieved, (if appropriate):** |
| Course | Level | Qualification | Date completed |
|  |  |  |  |
| **Please provide details of previous learning you have completed, if any:** |
| **If you know, how best do you like to learn?** |
| **Please provide details of the levels of support you have normally had in class/during learning, if any:** |
| **Emotional Wellbeing: Please use this section to describe your emotional wellbeing, such as: anxiety, depression, self harm, vulnerability, shyness etc.** |
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| **Counselling: If you have received any counselling or other professional psychological support we would be grateful if you would provide us with any information that is relevant to your application, if you are happy to do so.** |
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| **Please use this section to tell us why you would like to have a placement at St. Elizabeth’s College.** |
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| **Please tell us about the hobbies and interests you enjoy and vocational areas you are interested in:** |
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**Medical**

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| **General Practitioner (GP) Name:** |  |
| **Address:** |  | **Contact No:** |  |
|  | **E-mail Address:** |  |
| **Fax No:** |  |

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| **Please list the names of Medical Personnel you are currently receiving a service from (i.e. Neurology)** |
| Name | Position | Organisation Address | How often seen |
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| **Medical Diagnosis: *(Please include type and frequency of seizures)*** |
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| **Seizure Information** |
| **Before** a seizure I usually: |  |
|  |
| **After** a seizure I usually: |  |
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| I have seizures at night  | **Yes / No** | If YES please tell us about the frequency and type of seizures: |
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| Date of last EEG: |  | Result |  |
| Date of last MRI scan: |  | Result |  |
| Other information relevant to seizure management: *( for example: intervention medication)* |
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| **Medication:** |
| Drug name | **Dosage** | Time/s given |
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**Epilepsy Classification** (please tick all that apply): Active

In remission (on medication)

In remission (off medication)

Single seizure

Non-epileptic (associated disorder)

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| Age at first seizure:…… | Most recent seizure:………………… | No of seizures in last 12mths:…… |

**Epilepsy Classification** (please tick all that apply) **Seizure Classification** (please tick all that apply)

Partial epilepsy Tonic/Clonic (includes tonic or clonic)

Generalised epilepsy Absences

Primary generalised Myoclonic Jerks

Secondary generalised Drop attacks

Specific Syndrome Complex partial seizures

 Simple partial seizures

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| **Allergies/Drug sensitivity, for example foods, pollen, animals etc.** |
| 1. |
| 2. |
| 3. |
| 4. |

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| **Mobility:** |
| I can walk independently |  **Yes / No** |
| I need help with: |  |
| I use these aids to help me: |  |
| When I go out I need help to get about: (please specify help required) |  |
|  |
| I have fallen in the last 12 months |  **Yes / No** |
| The reason/s I have fallen are: |  |
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| Previous fractures:If YES what was broken and when: |  |
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| I have a history of Osteoporosis |  **Yes / No** |

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| **Sensory Assessment:** |
| I have difficulty with my vision |  **Yes / No** |
| I wear glasses |  **Yes / No** |
| I have other visual difficulties (please specify) |  |
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| **Hearing:** |
| I have difficulty with my hearing |  **Yes / No** |
| I use hearing aid/s |  **Yes / No** |
| I have other difficulties with my hearing (please describe) |  |
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| **Mental Health:** |
| I have experienced difficulties with my mental health | **Yes / No State which service:** |
| I am under the care of a psychiatrist or psychologist  | **Yes / No** **....... hours per week**  |
| At times I need help with behaviour management, (please also see Education section, page 3) | **Yes / No** |
| If **Yes to any of the above**, please describe help/present input  |  |
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| **Continence:** |
| I generally have normal bladder function |  **Yes / No** |
| I can usually control my bowel movements |  **Yes / No** |
| I wear pads during the day |  **Yes / No** |
| I wear pads during the night  |  **Yes / No** |
| I wear pads when I go out  |  **Yes / No** |
| I only have continence difficulties during seizures / epileptic activity |  **Yes / No** |
| Other information: (e.g. urinary infections) |  |
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| **Dietary Information:** |
| My current weight is:  |  \_\_\_\_\_\_\_\_\_ **Kg** |
| I have special dietary requirements |  **Yes / No** |
| If **Yes,** please specify requirements  |  |
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| Immunisation Details |  |
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| Date of Last Tetanus Injection |  |

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| **Sleeping:** |
| Do you have difficulties settling at night |  | **Yes / No** |
| If YES please tell us what the difficulties are and how they are helped |  |
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| Do you usually wake during the night |  |  | **Yes / No** |
| If YES state what wakes you, how often and what resettles you  |  |  |
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**Therapy**

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| Physiotherapy: |
| I am currently receiving Physiotherapy | Yes / No ....... hours per week |
| If YES please tell us why and how often you receive the service |  |
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| **Occupational Therapy:** |
| I am currently receiving Occupational Therapy | **Yes / No ....... hours per week** |
| If YES please tell us why and how often you receive the service |  |
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| **Speech:** |
| I am currently receiving Speech Therapy | **Yes / No ....... hours per week** |
| If YES please tell us why and how often you receive the service |  |
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| **Do you have any problems understanding others’ speech?** | **Yes / No**  |
| If YES please provide details |  |
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| **How do you express yourself? Please provide details:** |
| **Speech** |  |
| **Signing/non verbally** |  |
| **Communication aid** |  |

**Additional information**

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| **Is there any other information you feel we need to know about relevant to your application? Please use this space to tell us** |
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| **Name and address/contact details of person completing form:****(If different from front page)** |  |
| Relation to applicant: |  |

Date form completed …………………………

Thank you for the completion and return of this information.

The College will monitor applications to the College on the grounds of gender, ethnicity, religion and belief, sexual orientation and transgender status, in accordance with the Single Equality Scheme and Action Plan. These will be reported regularly to the College Leadership Group and Governing Body and included in the Annual Equality & Diversity Report.

**Admissions use only:**

|  |  |
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| **Proof of EU, EEA and eligible overseas dependent territories.** | **Please circle: Yes No** |
| **Photocopy of proof of eligibility taken:****By whom:** | **Please circle: Yes No****Name:****Signature:** **Position:** **Date:****Countersigned by:****Name:****Signature:** **Position:** **Date:** |