

# TRELOAR COLLEGE APPLICATION FORM

*Treloar College strives for excellence in education,  
therapy and care in environments which encourage  
disabled individuals to achieve their potential.*

Place required for (year of entry):

Name:

Form to be returned to Treloar College by:

1. ABOUT THE APPLICANT	
Surname:	First names:
Known as / familiar name:	Age:
Date of birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
No. of brothers and sisters:	Position in family: e.g. 2nd youngest
Nationality:	Religion:
Language used at home:	Ethnic origin:
Details (if applicable) of custody, care, fostering, 'looked after child', etc.	
Home address:	
Postcode:	
Disability: <i>Note: there is space for additional medical information on page 4</i>	
Does the applicant have: Memory deficit: <input type="checkbox"/> YES <input type="checkbox"/> NO                      Perceptual deficit: <input type="checkbox"/> YES <input type="checkbox"/> NO If YES please give brief details:	
2. NAME(S) OF PARENT(S) or CARER(S)	
<b>NAME:</b>	Occupation:
Relationship to applicant:	
Address (if different to above)	<b>CONTACT DETAILS</b>
	Home telephone:
	Work telephone:
	Mobile telephone:
	e-mail address:
<b>NAME:</b>	Occupation:
Relationship to applicant:	
Address (if different to above)	<b>CONTACT DETAILS</b>
	Home telephone:
	Work telephone:
	Mobile telephone:
	e-mail address:
Tick here <input type="checkbox"/> if a second copy of student reports should be sent to this second address.	

### 3. EDUCATION

#### CURRENT / LAST SCHOOL

Name:

Address:

Postcode:

Contact name:

Telephone:

#### Local authority (LA):

	YES	NO	
Does the applicant have a statement of special education needs? <i>If YES, please attach a copy of his or her last Annual Review.</i>	<input type="checkbox"/>	<input type="checkbox"/>	
Does the applicant receive additional support in the classroom? <i>If YES, how much?</i>	<input type="checkbox"/>	<input type="checkbox"/>	
Is the applicant disapplied from any part of the National Curriculum?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the applicant have an educational psychologist's report? <i>If YES, please attach a copy of the last report.</i>	<input type="checkbox"/>	<input type="checkbox"/>	
Please attach results of any standardised tests: <i>e.g. WISC, BAS, Ravens Matrices</i>	<input type="checkbox"/>	<input type="checkbox"/>	
Please state National Curriculum Levels in	<b>English Level:</b>	<b>Maths Level:</b>	<b>ICT Level:</b>

#### If the applicant has already achieved qualifications, please attach copies of results slips or certificates.

Details of GCSEs taken or to be studied:

#### POSSIBLE AREA OF STUDY AT TRELOAR COLLEGE

Please tick (✓) areas of interest:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Art and Design     | <input type="checkbox"/> Health and Social Care                                  | <input type="checkbox"/> Horticulture                |
| <input type="checkbox"/> ICT                | <input type="checkbox"/> Media   | <input type="checkbox"/> Office Skills and Retailing |
| <input type="checkbox"/> Performing Arts    | <input type="checkbox"/> Photography   | <input type="checkbox"/> Sport and Leisure Studies   |
| <input type="checkbox"/> Travel and Tourism | <input type="checkbox"/> A Levels / International Baccalaureate at Alton College |  |

Likely level of study (*use Treloar College Curriculum Guide p10 to help you*)

- Pre-entry       Entry       Level 1       Level 2       Level 3

### 4. LEISURE INTERESTS & ACTIVITIES, SPORT, HOBBIES, CLUBS

### 5. MEDICAL DETAILS

Name of General Practitioner (GP):

NHS Number:

Address:

Postcode:

Telephone:

*This is important information and can be obtained from your home area GP.*

Primary Care Trust (PCT):

Address:

Postcode:

Telephone:

Name(s) of Consultant(s):

Address and telephone:

Specialist area:  
*e.g. Orthopaedic, Paediatric, etc.*

**Does the applicant have, or require treatment for, any of the following?** If YES, please give brief details.

**YES**

**NO**

Epilepsy

Diabetes

Asthma

Eczema

Heart problems

Eyesight problems

Hearing problems

Allergies

Other

## 6. MEDICATION

**Drug**

**Dosage**

**When and how administered**

Please use a separate sheet if you require more space. Tick here  if you have included a separate sheet.

## 7. DIETARY / FEEDING REQUIREMENTS

Please give details of any special dietary requirements, food allergies, swallowing difficulties or special feeding arrangements:

## 8. THERAPY

### PHYSIOTHERAPY

**Yes**

**In the past**

**No**

Does the applicant receive physiotherapy?

Name of current therapist:

Telephone:

e-mail:

Therapy involved and frequency of treatment:

<b>SPEECH AND LANGUAGE THERAPY</b>			
	<b>Yes</b>	<b>In the past</b>	<b>No</b>
Does the applicant receive Speech and Language Therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name of current therapist:		Telephone:	
Therapy involved and frequency of treatment:		e-mail:	
<b>OCCUPATIONAL THERAPY</b>			
	<b>Yes</b>	<b>In the past</b>	<b>No</b>
Does the applicant receive Occupational Therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name of current therapist:		Telephone:	
Address:		e-mail:	
Therapy involved and frequency of treatment:			
<b>OTHER THERAPIST(S)</b>			
Please give details of involvement from other therapist(s) e.g. visual impairment advisor, counsellor, art or music therapist:			
<b>9. BEHAVIOUR</b>			
	<b>Yes</b>	<b>No</b>	<b>Please give details when appropriate</b>
Does the applicant have an awareness of danger?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the applicant exhibit any self-injurious behaviours?	<input type="checkbox"/>	<input type="checkbox"/>	
Are there any situations in which the applicant may be vulnerable?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a history of aggressive behaviour towards:	<input type="checkbox"/>	<input type="checkbox"/>	a)
a) peers	<input type="checkbox"/>	<input type="checkbox"/>	b)
b) staff	<input type="checkbox"/>	<input type="checkbox"/>	c)
c) parents / carers?	<input type="checkbox"/>	<input type="checkbox"/>	
Please detail any difficult behaviour the applicant may present, factors that trigger it and strategies used to modify it:			
<b>10. SKILLS, INDEPENDENCE &amp; SOCIAL INTERACTION</b>			
<b>MOBILITY, COMMUNICATION AND SOCIAL</b>			
<b>Primary mobility</b> please tick (✓) 1 only:			
<input type="checkbox"/> Ambulant <input type="checkbox"/> Manual wheelchair user <input type="checkbox"/> Powered wheelchair user <input type="checkbox"/> Attendant-controlled wheelchair user			
<b>Is the applicant able to:</b>	<b>Yes</b>	<b>No</b>	<b>Please give details when appropriate</b>
Drive a powered wheelchair independently?	<input type="checkbox"/>	<input type="checkbox"/>	
Use a manual wheelchair independently?	<input type="checkbox"/>	<input type="checkbox"/>	
Walk unaided?	<input type="checkbox"/>	<input type="checkbox"/>	
Go out alone in the community?	<input type="checkbox"/>	<input type="checkbox"/>	
Communicate so as to be easily understood?	<input type="checkbox"/>	<input type="checkbox"/>	
Understand verbal information in line with other abilities?	<input type="checkbox"/>	<input type="checkbox"/>	
Use signing or gesture to communicate?	<input type="checkbox"/>	<input type="checkbox"/>	

Does the applicant:	Yes	No	Please give details when appropriate
Interact with adults only?	<input type="checkbox"/>	<input type="checkbox"/>	
Prefer his / her own company?	<input type="checkbox"/>	<input type="checkbox"/>	
Occupy himself / herself?	<input type="checkbox"/>	<input type="checkbox"/>	
Enjoy being part of a group?	<input type="checkbox"/>	<input type="checkbox"/>	
Has the applicant stayed away from home before?	<input type="checkbox"/>	<input type="checkbox"/>	
Has the applicant boarded before?	<input type="checkbox"/>	<input type="checkbox"/>	
Has the applicant ever shared a room?	<input type="checkbox"/>	<input type="checkbox"/>	
Has the applicant had difficulty when staying away from home?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>SLEEPING</b>			
<b>Does the applicant:</b>	<b>Please give details</b>		
Sleep in: <input type="checkbox"/> an adjustable bed <input type="checkbox"/> a standard bed?			
Sleep with: <input type="checkbox"/> a pressure relief mattress <input type="checkbox"/> another type of mattress?			
Sleep with: <input type="checkbox"/> side rails <input type="checkbox"/> support bars <input type="checkbox"/> other bed accessories?			
Require intensive supervision at night? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please give details of any bedtime/morning routines:			
<b>CONTINENCE</b>			
Does the applicant:	Yes	No	Please give details/manufacturer
Use the toilet independently day and night?	<input type="checkbox"/>	<input type="checkbox"/>	
Have a catheter, colostomy or anything needing specialist care?	<input type="checkbox"/>	<input type="checkbox"/>	
Indicate the need for the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	
Sit on the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	
Need incontinence pads during the day / night?	<input type="checkbox"/>	<input type="checkbox"/>	
Need toileting at night?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>11. APPLIANCES AND EQUIPMENT</b>			
<b>MOBILITY</b>			
Does the applicant use:	Yes	No	
Walking aids?	<input type="checkbox"/>	<input type="checkbox"/>	
Scooter?	<input type="checkbox"/>	<input type="checkbox"/>	
Seating systems?	<input type="checkbox"/>	<input type="checkbox"/>	Is the applicant happy with them? <input type="checkbox"/> Yes <input type="checkbox"/> No
Switches?	<input type="checkbox"/>	<input type="checkbox"/>	Is the applicant happy with them? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>DINING ROOM</b> Please tick boxes (✓) and give details / manufacturer as appropriate			
Eating: <input type="checkbox"/> Neater-Eater <input type="checkbox"/> Winsford <input type="checkbox"/> Independent <input type="checkbox"/> Other:			
Mealtime assistance required: <input type="checkbox"/> Feeding <input type="checkbox"/> Carrying <input type="checkbox"/> Cutting <input type="checkbox"/> Other:			
Typical time taken for a main meal:                      minutes			
<input type="checkbox"/> Adapted cutlery <input type="checkbox"/> Drinking aids <input type="checkbox"/> Special crockery <input type="checkbox"/> Other:			
Table: <input type="checkbox"/> adjustable height <input type="checkbox"/> Other:			

<b>BATH</b>				<b>Please tick boxes (✓) and give details / manufacturer as appropriate</b>			
<input type="checkbox"/> Standard <input type="checkbox"/> Parker <input type="checkbox"/> Aquanova <input type="checkbox"/> Other:							
<b>SHOWER</b>							
<input type="checkbox"/> Walk-in <input type="checkbox"/> Drop-down seat <input type="checkbox"/> Fixed seat <input type="checkbox"/> Shower chair <input type="checkbox"/> other:							
<b>TOILET</b>							
<input type="checkbox"/> Clos-o-mat <input type="checkbox"/> support bars <input type="checkbox"/> special e.g. Chailey / Crossland <input type="checkbox"/> other:							
<b>TRANSFERS</b>							
<input type="checkbox"/> Sliding sheet <input type="checkbox"/> Turning sheet <input type="checkbox"/> other:							
Sling make and model:							
Is the applicant able to do a standing transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No                      Is a hoist needed? <input type="checkbox"/> Yes <input type="checkbox"/> No							
<b>IN THE CLASSROOM</b>							
Computer: <input type="checkbox"/> Joystick <input type="checkbox"/> Trackerball <input type="checkbox"/> Standard Mouse <input type="checkbox"/> other:							
Computer: <input type="checkbox"/> Mini-keyboard <input type="checkbox"/> Standard keyboard <input type="checkbox"/> Keyguard <input type="checkbox"/> other:							
Does the applicant: <input type="checkbox"/> Handwrite <input type="checkbox"/> Type <input type="checkbox"/> other:							
	<b>Yes</b>	<b>No</b>	<b>Please give details/manufacturer</b>				
Does someone else write or type for the applicant?	<input type="checkbox"/>	<input type="checkbox"/>					
Does the applicant use specialist software to read and/or to produce work on a computer, e.g. Clicker / Penfriend?	<input type="checkbox"/>	<input type="checkbox"/>					
Does the applicant use communication equipment?	<input type="checkbox"/>	<input type="checkbox"/>					
Does the applicant use switches to control communication equipment in the classroom?	<input type="checkbox"/>	<input type="checkbox"/>					
Communication aids: <input type="checkbox"/> Lightwriter <input type="checkbox"/> Dynavox <input type="checkbox"/> Tellus <input type="checkbox"/> Word book <input type="checkbox"/> Symbol board <input type="checkbox"/> Other:							
<b>12. SOCIAL SERVICES</b>							
Name of Social Worker:				Telephone:			
Address:				e-mail:			
<i>Please attach copies of any reports produced by Social Services.</i>							
<b>13. CAREERS</b>							
Name of Connexions PA (Careers Adviser):				Telephone:			
Address:				e-mail:			
<i>Please attach a copy of Section 140 Final Year Assessment if available from Connexions.</i>							
<b>14. EXPECTATIONS</b>							
<b>Applicant:</b> Why do you think Treloar College is the right placement for you?							
<b>Parent(s) / Carer(s):</b> Why do you think Treloar College is the right placement and what are the three main priorities for your child?							
Any other information which may be helpful during the interview:							
<b>AND FINALLY ... Please complete the checklist overleaf and sign the form.</b>							

**REPORTS ENCLOSED *Please tick boxes***

- |   |  |
|---|--|
| <input type="checkbox"/> Section 140 Assessment                   | <input type="checkbox"/> Medical                             |
| <input type="checkbox"/> Annual Review                            | <input type="checkbox"/> Physiotherapy                       |
| <input type="checkbox"/> School report                            | <input type="checkbox"/> Speech and Language Therapy         |
| <input type="checkbox"/> Educational Psychologist                 | <input type="checkbox"/> Occupational Therapy                |
| <input type="checkbox"/> Results from standardised tests *        | <input type="checkbox"/> Exam results slips / certificates * |
| <input type="checkbox"/> Other ( <i>please list and enclose</i> ) | * if applicable  |

**SIGNATURES**

Information on this form is provided by:

Name(s) IN CAPITALS:

Address and telephone if different from that stated on page 1:

Signature(s)

Date:

**WHAT DO I DO NOW?**

1. Please check that you have completed this form as fully as possible and that you have got copies of all the reports you need to send.
2. Please return this form and all other information, by the date shown on the front page of the form, to:  
Claire Williams  
Recruitment and Marketing Manager  
Treloar College  
Holybourne  
Alton  
Hampshire GU34 4EN

Short listing for interview takes place in July.

**DATA PROTECTION**

Treloar College adheres 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 applicant.

By signing/completing this form you are agreeing to the above statement. If you do not agree to any aspect of this please indicate.



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

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