

Please complete this form as fully possible and return to: School Admissions, Treloar's, Holybourne, Alton, Hampshire GU34 4GL

Treloar's application form Primary and EYFS

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

Proposed year of entry (e.g. 2016):

Student Name:

Form to be returned to Treloar's by:

Please note that it is extremely important that we receive copies of all available reports in advance of assessment. We will not be able to progress your application if you do not send copies of all available reports.

Please indicate which reports are available and enclose copies of these:		
<i>Available</i>	<i>Not Available</i>	
<input type="checkbox"/>	<input type="checkbox"/>	Most recent SEN
<input type="checkbox"/>	<input type="checkbox"/>	Therapy reports
<input type="checkbox"/>	<input type="checkbox"/>	Annual Review of SEN
<input type="checkbox"/>	<input type="checkbox"/>	Most recent report from current placement
<input type="checkbox"/>	<input type="checkbox"/>	Most recent Medical report
<input type="checkbox"/>	<input type="checkbox"/>	Educational Psychologist report
<input type="checkbox"/>	<input type="checkbox"/>	Behavioural plans
<input type="checkbox"/>	<input type="checkbox"/>	Visual Impairment report
		EYFS progress check at age 2
		EYFS profile
		Birth certificate
Information on this form is provided by: Name(s) IN CAPITALS:		
Address and telephone if different from that stated on page 3:		
Signature(s)	Date:	
WHAT TO DO WITH THE COMPLETED APPLICATION: <ol style="list-style-type: none"> Please check that you have completed this form as fully as possible and that you have retained copies of all the reports you need to send. Please return this form and all other information to: School Admissions, Treloar's, Holybourne, Alton, Hampshire, GU34 4GL 		

DATA PROTECTION

Treloar School and 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. We are required by law to pass on certain information to the provider of youth support in your area. This is the local authority support service for young people aged 13 to 19 in England. We must provide your address, your date of birth and any further information relevant to the support services' role. By signing/completing this form you are agreeing to the above statement.

If you do not agree to any aspect of this please indicate here

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
Language used at home:	Religion:
Ethnic origin:	
<input type="checkbox"/> Asian/A.British – Bangladeshi <input type="checkbox"/> Asian/A.British – Indian <input type="checkbox"/> Asian/A.British – Pakistani <input type="checkbox"/> Asian/A.British – other <input type="checkbox"/> Black/Blk.British – African <input type="checkbox"/> Black/Blk.British – Caribbean <input type="checkbox"/> Black/Blk.British – other <input type="checkbox"/> Chinese <input type="checkbox"/> Mixed – white/Asian <input type="checkbox"/> Mixed – white/blk African <input type="checkbox"/> Mixed – white/blk Caribbean <input type="checkbox"/> Mixed – other <input type="checkbox"/> White – British <input type="checkbox"/> White – Irish <input type="checkbox"/> White – other <input type="checkbox"/> Other	
Details of custody, care, fostering, 'looked after child' status, etc. (if applicable):	
Home address:	
Postcode:	
Principal Disability: <i>Note: there is space for additional medical information on page 4</i>	
Additional Disabilities:	
Which Year Group is your child in at this time?	
Is your child eligible for free early years education? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. NAME(S) OF PARENT(S) or CARER(S)	
NAME:	Relationship to applicant:
Address (if different to above)	CONTACT DETAILS
	Home telephone:
	Work telephone:
	Mobile telephone:
	e-mail address:
	Emergency contact no:
NAME:	Relationship to applicant:
Address (if different to above)	CONTACT DETAILS
	Home telephone:
	Work telephone:
	Mobile telephone:
	e-mail address:
	Emergency contact no:
Tick here <input type="checkbox"/> if a second copy of student reports should be sent to the second address.	

3. EDUCATION

CURRENT placement

Name:

Address:

Postcode:

Contact name:

Telephone:

Name and address of Local authority (LA):

Does the applicant receive additional support in the classroom? Yes No

If YES, how much, and what is the nature of the support?

Is the applicant disapplied from any part of the National Curriculum? Yes No

State National Curriculum/P Levels in:

English

Maths

ICT

4. 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

Regular and/or significant pain

Other – please specify here:

5. 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.

6. DIETARY/FEEDING REQUIREMENTS

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

7. THERAPY

PHYSIOTHERAPY

	Yes	In the past	No
Does the applicant receive physiotherapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name of current therapist:	Telephone:		
	e-mail:		
Therapy involved and frequency of treatment:			

SPEECH AND LANGUAGE THERAPY

	Yes	In the past	No
Does the applicant receive Speech and Language Therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name of current therapist:	Telephone:		
	e-mail:		
Therapy involved and frequency of treatment:			

OCCUPATIONAL THERAPY

	Yes	In the past	No
Does the applicant receive Occupational Therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name of current therapist:	Telephone:		
	e-mail:		
Therapy involved and frequency of treatment:			

OTHER THERAPIST(S)
Please give details of involvement from other therapist(s) - e.g. counsellor, art or music therapist, visual impairment adviser & ophthalmic specialist:

8. BEHAVIOUR			
	Yes	No	Please give details when appropriate
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:			
a) peers	<input type="checkbox"/>	<input type="checkbox"/>	a)
b) staff	<input type="checkbox"/>	<input type="checkbox"/>	b)
c) parents/carers?	<input type="checkbox"/>	<input type="checkbox"/>	c)
Please detail any difficult behaviour the applicant may present, factors that trigger it and strategies used to modify it:			

9. SKILLS, INDEPENDENCE & SOCIAL INTERACTION			
Primary mobility please tick (✓) 1 only:			
<input type="checkbox"/> Fully ambulant	<input type="checkbox"/> Walks with crutches/aids	<input type="checkbox"/> Manual wheelchair user	
<input type="checkbox"/> Powered wheelchair/scooter user	<input type="checkbox"/> Attendant-controlled wheelchair user	<input type="checkbox"/> Other:	
Local Wheelchair Centre:			
Does the applicant:	Yes	No	Please give details when appropriate
Have a loaned manual wheelchair?	<input type="checkbox"/>	<input type="checkbox"/>	
Have an EPIOC (Electrically Powered Indoor/Outdoor Chair)?	<input type="checkbox"/>	<input type="checkbox"/>	
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"/>	
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"/>	
CONTINENCE			
Does the applicant:	Yes	No	Please give details when appropriate
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"/>	

COMMUNICATION			
Does the applicant:	Yes	No	Please give details when appropriate
Have a hearing impairment?	<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"/>	
Please give details of any communication aids: <input type="checkbox"/> Voice Output Communication Aid <input type="checkbox"/> Word book <input type="checkbox"/> Symbol board			
NOTE: If the applicant uses any communication equipment it is ESSENTIAL that you bring it with you.			

10. SOCIAL SERVICES	
Name of Social Worker:	Telephone:
Address:	e-mail:
<i>Please attach copies of any reports produced by Social Services.</i>	

11. EXPECTATIONS

Parent(s)/Carer(s):

Why do you think Treloar School is the right placement and what are the three main priorities for your child?

Any other information which may be helpful during the interview:

Please indicate how you heard about Treloar's:

- Advert in disability publication:
- Directory:
- Disability support group:
- Exhibition:
- Internet, including Treloar's website:
- Other professionals/specialists:
- Parent of current school/college pupil/student:
- Parent of former school/college pupil/student:
- Press/newspaper article:
- Reputation or work of mouth:
- Local Authority:
- Other (please specify):

AND FINALLY ... please ensure you have completed the checklist at the front of this document and signed the form.