

#### Course Application Form

**In accordance with data protection legislation please confirm by completing this form you agree that the information on this form is correct and that you consent to share the details of all named within it for the purposes of referral and contact**

**YES NO**

|  |
| --- |
| **Date form completed**  |
| **Family Address**  |
| **Postcode**  | **Email**  |
| **Parent/Carer (1):**  | **m / f** | **Ethnicity**  |
| **Relationship to child:** | **Tel:**  |
| **Parent/Carer (2)**  | **m / f** | **Ethnicity**  |
| **Relationship to child** | **Tel:** |
| **ADHD Child**  | **d.o.b.**  | **Ethnicity**  |
| **Gender** | **Male inc Trans man** [ ]  | **Female inc Trans woman** [ ]  |
| **Non Binary** [ ]  | **Other** [ ]  |
| **Not Known** [ ]  | **Person declined to state** [ ]  |
| **Gender at birth** | **Same as assigned at birth** [ ]  | **Not same as assigned at birth** [ ]  |
| **Not known** [ ]  | **Person declined to state** [ ]  |
| **NHS No.** | **GP Practice** |
| **Sibling 1** | **d.o.b.**  | **m / f** | **Ethnicity**  |
| **Sibling 2** | **d.o.b.**  | **m / f** | **Ethnicity**  |
| **Sibling 3**  | **d.o.b.**  | **m / f** | **Ethnicity**  |
| **Sibling 4** | **d.o.b.**  | **m / f** | **Ethnicity**  |
| **ADHD Child** | **Being assessed YES** [ ]  **NO** [ ]  | **Diagnosis YES** [ ]  **NO** [ ]  |
| **Medication YES** [ ]  **NO** [ ]  | **SEN Plan? YES** [ ]  **NO** [ ]  |
| **EHC? YES** [ ]  **NO** [ ] **Tel:** | **EHA? YES** [ ]  **NO** [ ] **Lead** |
| **If NO is assessment ongoing? YES** [ ]  **NO** [ ]  | **Lead Professional:** |
| **Next meeting date:** |
| **School Attended**  |
| **Details of any learning difficulties (e.g. dyslexia, developmental etc.)** |
| **Details of additional medical conditions** |
| **Details of prescribed medications, learning support, therapy or other support being provided** |
| **Any additional information to support the referral** |