

For Office Use		
		Initial
Date Recieved:		
Date IC Booked:		
Date of IC:		



RAINBOW HUB

CHILDREN SERVICES APPLICATION FORM

Child's Name:

Date of Birth:

Please tick the service you are interested in:

Conductive Education		Mobility	
Physiotherapy		Stay & Play	
Rebound Therapy		Family Support	
Step Safe			

PERSONAL INFORMATION ABOUT THE CHILD

ABOUT THE CHILD	
Child's first name	Date of Birth
Child's surname	
Child's Sex	Age
Address	Day telephone number
Postcode	Evening telephone number

Please attach a recent photo of your child here

Please return the form to:

Rainbow Hub
Salt Pit Lane
Mawdesley
Ormskirk
L40 2QX

ABOUT THE MAIN CARERS

Parent / Primary carers name	Parent / Secondary carers name
Age	Age
Does this person have parental responsibility?	Does this person have parental responsibility?
Occupation	Occupation
Contact Telephone numbers (mobile or work)	Contact Telephone numbers (mobile or work)
E-mail Address	E-mail Address
If neither of the above have parental responsibility please provide name and contact details of Social Worker	
Which parent/carer(s) does the child normally live with?	

EMERGENCY CONTACTS IN ADDITION TO MAIN CARER(S)

Emergency Contact person #1	Emergency Contact person #2
Relationship to child	Relationship to child
Home telephone number	Home telephone number
Mobile number	Mobile number

MEDICAL HISTORY

ABOUT YOUR CHILD'S CONDITION

Does your child have a diagnosed condition? YES/NO If Yes, please specify (nb If you have Cerebral Palsy please specify i.e. quadriplegia, diplegia, hemiplegia, ataxia, athetosis) Which professional diagnosed your child and when?
When did you first notice problem's with your child's development? Please give approximate age and specify problems.
Please give brief summary of the circumstances surrounding your child's birth, mother's pregnancy, other pregnancies, miscarriages etc...

<p>At how many weeks gestation was your child born?</p> <p>What was his/her birth weight?</p> <p>Did your child receive any aftercare (e.g. oxygen, surgery etc...) following birth or acquired brain injury if so, please specify</p>
<p>If your child has an acquired brain injury, please state how and when the brain injury took place.</p>
<p>What is your child's present state of health? (Please give details of any specific medical problems)</p>
<p>Does your child have epilepsy? YES/NO If yes, how do your child's seizures present themselves and how long do they last for? Does your child have any medication to control their seizures? If yes, please specify</p>
<p>Has your child had any orthopaedic surgery? If yes please give details</p>
<p>Does your child have any difficulties in the following areas: If yes please give details</p> <p>Hearing difficulties:</p> <p>Visual difficulties:</p> <p>Other sensory difficulties:</p>
<p>Is your child on any other medication? If yes please give details</p>
<p>Does your child have any allergies? If yes please give details</p>

DEVELOPMENT

YOUR CHILD'S DEVELOPMENT

If your child has reached any of the milestones below, please give approximate ages when achieved. If they are still working towards these skills please try to indicate the current level of ability. (Please use an additional sheet if required).

Head Control (i.e. able to lift head up):

Rolling:

Crawling:

Sitting (on floor or on chair):

Standing:

Stepping:

Moving from sitting to standing:

Walking:

Use of hands (i.e. grasping, releasing, transferring objects):

SELF CARE SKILLS

Please give details of your child's current level of abilities in the following areas:

Eating/drinking (If your child has any specific difficulties with eating or drinking (e.g. tube fed, aspiration etc... please specify):

Dressing/undressing:

Potty/toilet training:

COMMUNICATION

Please describe how your child indicates his/her needs (e.g. smiling, crying, talking etc...)

Give details of any assistive devices used to communicate (e.g. signing, symbols, computer etc...)

Does your child have any difficulties in understanding spoken language? If yes please specify

GENERAL INFORMATION

ANY EXTRA INFORMATION

Does your child have any siblings? or people that they are close to other than their parents/primary carers?

Does your child follow any religious and/or cultural beliefs that you would like us to be aware of?

What activities does your child particularly enjoy? Or particularly dislike? (e.g. favourite toys, people they spend time with etc...)

Please give details of any other activities, interventions or therapies that your child attends (e.g. swimming, horse riding, physiotherapy, previous conductive education etc.)

Does your child use any assistive devices (e.g. standing frame, splints, boots etc...)? If yes please give details

Does your child attend school, nursery, childminder etc...If yes please give details

How did you find out about our services?
Do you have any knowledge of Conductive Education? If yes please give details
What do you hope your child will achieve through our services?
Any other comments you would like to make about your child

THANK YOU

One of our team will contact you shortly to organise a consultation for your child.

The information I have written on this form is true and accurate to the best of my knowledge and I understand that this form is not an acceptance of a place for my child but is used as part of an assessment tool to assess whether any of the services offered by RH are suitable for my child.

SIGN

PRINT

DATE

RELATIONSHIP TO CHILD



RAINBOW
HUB

FOLLOW YOUR DREAMS, WHATEVER YOUR ABILITY