**Leap to learn**

 **Provider Referral Form**

|  |
| --- |
| **Pupil Information** |
| **Full Legal Name:** |  |
| **Preferred Name:** *(if applicable)* |  |
| **School Year:** |  |
| **DOB:** |  |
| **Address:***(including Postcode)* |  |
| **Statemented:** | Yes / No  *If yes, please provide details* |
| **LAC:** | Yes/ No  *If yes, please provide details* |
| **Contact number** |  |
| **Support Worker Information:** |  |
| **DSP** |  |
| **Additional Learning Needs:***(please highlight)* | ADHDASDODDMild Learning DifficultiesModerate Learning DifficultiesSevere Learning DifficultiesAnxietyDepressionSelf -harmOther *(please specify):**Please provide details:* |
| **Medical Issues / Requirements:***(please highlight)* | AsthmaHayfeverEpilepsyDiabetesAllergies *(please specify):*Food Intolerances *(please specify):*Other *(please specify):**Please provide full details including information on any medication that needs to be dispensed in education hours (i.e. name of medication; when, who and how medication* *will be dispensed):*Health Care Plan required: Yes / No |
| **Brief Background:** *(including any other relevant information)* |  |

|  |
| --- |
| **Attendance Details**  |
| **Pattern of Attendance/Other Providers Attended:***(including days and times)* |  |
| **Proposed Start Date:**  |  |