New Client Registration

Parents/Carers

Title (Mr/Mrs/Ms) .......................................................................................

Full Name ...............................................................................................

Nationality...................................................................................................

Email ..........................................................................................................

Preferred Language ...................................................................................

Telephone Number Mobile.........................................................................

Telephone Number Home..........................................................................

Address......................................................................................................

....................................................................................................................

EmergencyContact...................................................................................

Child/children

Name/s..........................................................................................................

Girl/Boy/preferred.......................................................................................

DoB.............................................................................................................

Disability/Special need...............................................................................

Communication methods...........................................................................

Visual/hearing requirements......................................................................

Wheelchair User........................................................................................

Any special equipment/orthotics...............................................................

Medical Requirements ...............................................................................

Therapeutic Requirements. .......................................................................

Emotional Requirements ...........................................................................

Social Requirements.................................................................................

Educational Requirements.........................................................................

Special Needs Contract Placement Requirement: Please indicate times/days/hrs

Part Time ........................................................................................

Full Time............................................................................................

Weekends.................................................................................................

Term Time ..............................................................................................

Holidays ....................................................................................................

Over night ..................................................................................................

Live in ........................................................................................................

Travel Abroad.............................................................................................

Family

No. of siblings............................................................................................

Please state if any additional support or care is required for siblings.

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Please use the space below or another sheet to share what you would like from having a Special needs placement:

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Name ..........................................................................................................

Date ......................................................................................................

Please return this form direct to contact@endeavourspecialneeds.co.uk