**10-18y Referral Form for Short Breaks Weekend Events**

**Please rank your choices below on a scale of 1- 4 (1 as your favourite choice, 4 being least). We will try to allocate according to your preferences, however, to ensure places are distributed equally and fairly to as many children and young people as possible, we cannot guarantee you will be given all sessions requested.**

**Please note, there will be a charge of £5 per CYP, per session for each of the activities below payable to I am autism in cash on the day of the event.**

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| **Date** | **Time** | **Event** | **Rank you want to give** |
| Sat 23rd November  | 10.30am – 3.30pm | Kick Air trampolining |  |
| Sat 14th December | 12.30pm – 5pm | Relaxed Performance of Jack and the Beanstalk Pantomime |  |
| Sat 28th December | 11am – 3pm | Youth Club |  |
| Sat 4th January | 11am – 3pm | Family Group |  |

**Personal Information**

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| **Details of Individual:** |
| Name of Person: | Age: |
| Gender: | Date of Birth: |
| Email Address: |
| Telephone Number: |
| Address: |
| Local Authority:  |  |
|  |
| **Details of Parent/Carer:** |
| Name: |
| Telephone Number: | Date of Birth: |
| Email Address: |
| Address if different from above:  |
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| **Diagnosis Information:** |
| Does your child have a diagnosis of autism spectrum condition? | Yes / No / On pathway |
| If they do, please give details of diagnosis (especially social areas that may need supporting – such as verbal capacity etc): |
| **Additional Medical Conditions: Please tick below or use the space to inform us of any additional diagnoses** |
| ADD OCD Dyslexia Tourette’sADHD PDDNOS PDD DyspraxiaOther:………………………………………………………….. |
| **Education:** |
| School/College: | Year group: |

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| **Other Information:** |
| Please give details of any allergies: |
| Please give details of any dislikes or phobias: |
| Please give details of any regular medication taken and what it is for: |
| Please give details of what the individual likes to do. What interests/hobbies does the individual have? |
| Does the young person experience or exhibit any of the following?Outbursts Self-harmMeltdowns Anxiety Aggression Depression Physical violence Please tell us about the nature of these and any known triggers |
| Please add any other information of which you think I AM should be made aware. |
| **Equal Opportunities Monitoring:****For I AM to ensure that we are reaching all sections of the community please provide the following information:** |
| Ethnic Origin: | Religion: |
| **Data Protection Act:** |
| The information you have provided on this form will be used exclusively for our project and will be stored in accordance with the principles of the Data Protection Act 1998. We need your signed consent to hold the information on our databases. Please be assured it will be held for the purpose it as provided, and we will be sensitive with your information at all times.  |
| **I confirm that the information provided is true and accurate to the best of my knowledge and belief. I consent to my information being held on the I AM database and I agree to inform I AM of any changes such as address, telephone number, medication etc.** |
| Signed: | Date: |
|  |
| **Please return form to:** Email: wendy.griffin@i-am-autism.org.uk  |