We are committed to making sure that school is a happy and successful experience for all of our children and young people. Where a child has a particular difficulty or need, we will do our best to put measures in place to overcome this.

We will treat what you have told us here sensitively. None of the information will be shared with other parents or pupils. The back page of this questionnaire provides more information about who this information will be shared with. If you need help to fill in this questionnaire please let us know.

Child's First Name……

Child's Surname/Family Name……

Date of Birth (dd/mm/yy)……/……../……

Gender (please tick) Boy ☐ Girl ☐

1. Please indicate whether your child has any long–standing illnesses, health problems or disabilities which mean that they have substantial difficulties with any of the areas of his/her life shown below? Please select all that apply. By long- standing we mean anything that has troubled them over a period of at least 12 months or that is likely to affect them over at least 12 months. Please exclude difficulties that you would expect for a child that age.

Mobility ☐

Hand movements – touching or holding ☐

Personal care – going to the toilet, dressing ☐

Eating and drinking without help ☐

Incontinence – wetting or drying ☐

Taking medication ☐

Communication – speaking with others, or understanding them ☐

Learning – numbers, letters, words ☐

Hearing ☐

Vision including colour blindness ☐

Behaviour – very active, has a short attention span, behaves unacceptably ☐

Has fits or seizures ☐

Diagnosed with autism or Asperger Syndrome ☐

Has a life-limiting condition or requires palliative care ☐

Can be depressed, or anxious, or has an eating disorder ☐

Other (please describe other areas of great difficulty)…….

2. Does your child take any medication, use any physical aids or require any special diet or supplements?
Yes/No

3. If your child did not take this medication, use this physical aid or have a special diet or supplements, would he/she have substantial difficulties with any of the areas of life listed above? Yes /No

4. Has your child seen a professional, such as a paediatrician or a speech and language therapist because of the difficulty? Yes /No

   If YES please provide further details:
   …….
   ……
   ……

5. If you have indicated above that your child has difficulties, do these difficulties affect his or her :
   (Please tick as appropriate)

	Yes	Sometimes	No	Don't know
Classroom learning?				
Interaction with his or her classmates/peers?				
Joining in other school activities e.g. breaks social and leisure activities?				
Attendance at school				
Day to day life outside of school				

6. What sort of help or special equipment do you think your child needs so that they get on well at school?.....
   .....

We would be pleased to talk with you about your child's needs. Please supply your email address if you would like to arrange this. …….

Completed by (print name)……Date……..

Relationship to child…….

What happens to the Information You Give us?

We really appreciate your help with this questionnaire. The information will be used by the school to improve the way information on pupils' difficulties and disabilities is collected and used in schools to promote the wellbeing of children. No information will be published that would identify your child. By returning this form you are agreeing that information can be used in this way. The covering letter shows the person in the school who will open the envelope and see this information. Information will be shared with those staff in the school that support your child unless you ask us not to below.

Is there any person in the school who you <u>would not</u> like to share this information with?

Please name them……..