



Further Education Learner Application Form

**Please place
photograph of
learner here**

Learner name:

School name: (if appropriate)

Name of person completing this form and
relationship to learner:

Date place required from:

Type of Education placement required:

Day Residential

Thank you for your interest in Portland College.

Please complete this application form with as much information as you can, the more details we have, the better we can support you.

Please ensure that you enclose your most recent Education Health Care Plan (EHC plan).

Failure to evidence information through your EHC plan or this application form will delay your application being processed.

Once we have received your completed application form and EHC plan, our Admissions team will contact you to arrange an assessment.

After this assessment, should our Multi-Disciplinary Team feel that we can support you and your needs, we will contact you to offer a placement which will be subject to funding. Should this offer be accepted by yourselves, we will then create an Initial Assessment Report which will be sent to your Local Authority as part of a funding request. You will then be contacted directly by your Local Authority to inform you if funding has been agreed and your place at Portland College confirmed.

If you would like to extend your personal and social progression around your education programme, we have Portland Freedom based on the same campus. Portland Freedom is assessed and funded separately to the education provision.

Portland Freedom has been designed to meet your specific individual requirements, offering Day Centre services, Short Breaks and an Independent Living service, all with a range of bespoke and structured schedules.

For more information, please contact the Freedom team on **01623 494322**.



Contact information

Learner full name:

Known as:

Date of birth:

Address:

Telephone number:

Are you a Looked After Child, or in the care of your Local Authority?

Yes

No

Next of Kin

Name:

Relationship:

Address:

Telephone:

Mobile:

Email:

Emergency contact?

Yes

No

If No, please provide details of who is:

Please tick here if you would **NOT** like to be contacted via email or text regarding College events and promotions

GP Contact

Doctors name:

Surgery:

Address:

Telephone:

Religious or Cultural needs:

NHS number:

Medical Exemption number:



Contact information continued

School Contact

tick if not relevant

Name: Role:

Address:

Telephone: Email:

Social Worker

tick if not relevant

Name:

Address:

Telephone: Email:

Personal Advisor or SEN contact at your Local Authority

tick if not relevant

Name:

Address:

Telephone: Email:

Are you currently receiving any of the following therapies?

Physiotherapy

Occupational Therapy

Speech and Language Therapy

Other - please state:

Who, or where, originally referred you to Portland College? (please provide full contact details if relevant)



Information about you

What is your disability?

How does it affect your learning?

Please tell us about your personality, including your likes and dislikes.

What would you like to study at Portland College? (please tick all that interest you)

- Land based and Trade Industries
- Design, Technology and Retail Industries
- Service and Leisure Industries



Information about you continued

What are your future goals?

Have you taken part in any work experience or completed a work placement?

Yes No

If yes, please provide details, including contact details of the placement provider:



Educational details

Prior Achievements

Please detail your examination history and any other accredited achievements. We use this information to make sure that you have access to the appropriate study programme.

Title/Course	Awarding Body	Level(GCSE/Entry/Preentry)	Grade/Expected Grade

Do you have any non-accredited achievements? (eg. Communication, decision making, problem solving etc)

How do you like to record your work? (e.g. symbols, words, audio)

Please describe your basic/key skills in the following areas:

Literacy:

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Numeracy:

--

Information Technology:

--

Evidence of qualifications will be required at the point of enrolment.



Behaviour

Please describe some examples of any behaviours that may challenge your learning and others.
(please include all levels of behaviour)

How often do these behaviours occur?

When was the last occurrence of behaviour?

What triggers this behaviour? (e.g environment, other learners, change etc)

How often do these behaviours occur?

Never Occasionally Often Very Often

What are the early signs that staff need to be aware of before any behaviours occur? (pacing, crying, change in facial expression etc)

What strategies help to support with the behaviour to try and stop it? (e.g calm approach, reinforcements/rewards, proactive strategies, reactive strategies)

What will make the behaviour worse?

What helps staff to motivate you to stop the behaviours happening? (how do you like to be supported?)

How do you like staff to support after any behaviour? (post incident support)



Behaviour continued

Do you have a Behaviour Support Plan?

Yes

No

If yes, please ensure you enclose a copy of this.

Have you had any contact or support from any external services? (including CAMHS Child and Adolescent Mental Health Services, Psychology, Psychiatry, ICATT Intensive Community Assessment and Treatment Team)

Yes

No

If the answer is yes to the above question, please provide contact details:

Contact name:

Service:

Job role:

Address:

Telephone:

Email:

Contact name:

Service:

Job role:

Address:

Telephone:

Email:

Please provide any other information about your behaviour that you feel would be useful to accompany this application:



Behaviour - Risks

Are there any risks associated with the following?

Vulnerability - risks associated with being subjected to potentially abusive situations, stranger danger etc

Awareness of dangerous situations - risk associated with being unaware of dangerous situations e.g. road safety, or using equipment)

Interactions with other learners - risks associated with interactions with other learners, sexual boundaries, being a trigger for others

Absconding - risks associated with absconding from different environments



Communication

Are you currently seeing a Speech and Language Therapist?

Yes

No

What for? (e.g. speech, using signing?)

Do you enjoy communicating and spending time with others, or do you find this difficult?

Do you have difficulties understanding: (please tick all those that apply)

Spoken Language

What is happening around you

Please give any details:

Do any of the following things help you to understand: (please tick all that apply)

Objects

Photos

Pictures

Symbols

Signing

Single Words

Short Sentences

Please give any details:

How do you express yourself or get your message across?

Body Language

Facial Expression

Vocalisation

Single Words

Short Sentences

Fuller Sentences

Pictures/Photos

Symbols

Objects

Communication Aid

Speaking Switches

Speaking Buttons



Communication

If you use a communication aid, please provide the following details:

(If you do not have a Communication Aid, please feel free to leave this section blank)

Communication Equipment Details	Funded/ Owned by	Age	Warranty/ Insurance details

* We need this information in case of requesting additional equipment from the Local Authority

How do you access your Communication Aid?

- Eye Gaze
- Switch (Head/foot)
- Head Pointing
- Direct Access (touch)

Is this effective?

- Yes
- No

If no, why not

How do you communicate your basic needs or wants? (e.g Yes/No, I want, help me, go away etc)

How do you tell us when you are feeling thirsty/hungry/tired/happy/angry/in pain etc?



Assistive technology

How do you access computers?

- Switch
- Hands
- Eye Gaze
- Fingers (even one at a time)

What equipment do you use?

- Standard keyboard
- Rollerball Mouse
- Big Keys Board
- Joy Stick Mouse
- On Screen Keyboard
- Standard Mouse

Other

Do you use any specialist software?

- Grid 2 or 3
- Dolphin
- Clicker
- Windows accessibility features e.g magnifier
- Dragon (dictation)

Other

Eating and drinking

Do you have any special dietary needs (e.g. vegetarian, halal, diabetic, soft, liquidised, thickened etc)

- Yes
- No

If yes, please provide details:

Do you have or have you ever had any problems with chewing and swallowing?

- Yes
- No

If yes, please provide details:



Eating and drinking continued

Do you frequently cough when eating?

Yes No

Have you had any choking (blocked airway) incidents?

Yes No If so, when was the last one?

Do you have any thickened drinks?

Yes No

Do you have any specific likes or dislikes with eating or drinking? Please give details.

Do you require any changes to ordinary food textures and fluids?

Pureed Mashed down Chopped up With Gravy

Any other details?

Do you require any specific utensils for eating and drinking? Please give details. (e.g. special cups, size of cutlery used etc)

Please give a brief description of how you like carers to support you with eating and drinking. (e.g whether they should be at your right or left side, the pace at which you like to be given food, whether you like a drink between mouthfuls of food etc)

What is the best position for you to be in when eating and drinking? (e.g. in a manual wheelchair with head rest on, facing away from distraction in the room etc)

Do staff need to be aware of any anxiety or other issues during meal times?

Have you had a swallow assessment? Yes No

Please enclose any swallow assessment reports or eating and drinking guidance with this application form.



Occupational Therapy

Brief details of past and present Occupational Therapy including the name of your therapist, what you are working on etc. Please provide any information that you feel is important.

Do you have specific sensory needs which prevent you from learning? (May include not liking or needing a lot of touch, movement, sound etc)

Yes No

If yes, please describe:

Do you think you could become more independent in managing your personal care in these areas?

Toileting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Showering/bathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dressing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Grooming	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eating and drinking	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do you think you could become more independent in managing the following home-making skills?

Making a cold drink	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Making a hot drink	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Making a snack	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Making a meal	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cleaning	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Laundry	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shopping	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do you think you could become more independent at managing your money?

Yes No

Do you think you could become more independent using public transport?

Yes No



Medical History

Do you have a history of any of the following?

Please tick all boxes that are relevant and provide details where possible.

Epilepsy

If so, please complete the following:

How often do you have a seizure?

How does a seizure present?

How long do the seizures last?

Do you recognise any triggers?

Yes

No

What intervention do you require?

Diabetes (Insulin)

Diabetes (Non insulin)

Heart Problems

Mental Health Problems

Asthma

High Blood Pressure

Eating Disorder

Breathing Difficulties (e.g tracheotomy/oxygen/restriction/repeated chest infections)

Others (e.g. botox, spinal rods, tendon releases, hip displacements etc)

Please provide full details of any of the above, plus any other relevant medical history:

Multiple horizontal pink bars for providing details of medical history.

Do you have any continence needs?

Yes

No



Medical Information

Medication Prescribed	How is this taken? (tick all that apply)		
	Orally	Rectally	Peg-fed
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Please ensure that all medication provided is closed, in the correct packaging, ensuring all details are clearly labelled with the recipient's name.

We cannot administer medication if it is not in the correct packaging and labelled correctly.

Do you understand why you are taking this medication?

Yes

No

Do you self-medicate at the moment?

Yes

No

Do you have any PRN or Emergency medication?

Yes

No

If yes, please provide details:

Allergies or Drug Sensitivity (e.g foods, pollens, animals, latex etc)

1

2

3

4

5



Hearing and Vision

Do you have any hearing problems?

 Yes No

If so, do you have a hearing aid?

 Yes No

If yes to either question, please provide details, including when the battery was last checked:

Do you wear glasses?

 Yes No

If so, when do you wear them?

Do you have any other visual difficulties?

 Yes No

If yes, please provide details:



Sleeping, Dressing and Undressing

Please do not complete this section if you are applying for a day placement.

Do you have a sleeping routine?

 Yes No

Please provide details:

Do you like to be in a certain position to help you sleep?

 Yes No

Please provide details:

Do you have any special equipment?

 Yes No

Please provide details:

Who owns this equipment?

Are you able to use a call alarm system?

 Yes No

What do you use at home? Please provide details:

Are you able to direct your care needs?

 Yes No

Are you able to fully dress and undress yourself?

 Yes No

Are you able to make appropriate choices about clothing?

 Yes No

If you need assistance, are you able to direct your carers?

 Yes No

How many carers are required to help you dress?



Please ensure you complete this page, only if you are applying for a residential place or are considering some Portland Freedom respite.

Please ensure that you enclose a copy of your **Community Care Assessment, Care & Support Assessment, or CORE Assessment** with this application. Failure to enclose this information will result in a delay in the application process.

GP Contact

You have the option to register with our local GP, please indicate your preference: Yes No

If yes, a member from our nursing team will contact you to complete a registration form.

If no, please complete details below of your current GP practice:

Doctors Name:

Address:

Telephone No:

Please Note: In the case of a medical emergency, Portland College reserves the right to take decisions that would involve contacting our Local GP/emergency services due to our duty of care for all citizens/learners.

Has there been a **Power of Attorney** applied for on behalf of the individual named on the application form?

Yes No

If yes, please enclose the original documentation.



Physiotherapy

If you are currently seeing a Physiotherapist please provide their contact details:

How do you usually get around?

Do you need assistance to get around? (e.g pushing of wheelchair; supervision when walking/driving)

Yes No

If yes, please provide details:

Do you use any equipment to help you get around other than a wheelchair?

Orthotics Stick Standing Frame
 Trike Walking Frame
 Other?

Current physiotherapy goals or things to work towards:

Are you interested in aquatic physiotherapy?

Yes No

Are you interested in rebound physiotherapy?

Yes No

Would you be interested in extra physiotherapy sessions during College holiday time?

Yes No



Mobility

How do you transfer from the chair or bed? Please provide details.

Do you need any equipment or assistance to transfer?

Yes No

If yes, please provide details:

Pain

If you have pain on a regular basis, please supply us with the following information:

Where is it?

How often?

How would you describe it?

How do you relieve your pain?

On the scale below (0 being no pain, and 5 being pain that makes you cry) please mark your pain:

At its best: 0 1 2 3 4 5

At its worst: 0 1 2 3 4 5

Any comments:



Equal Opportunities

For monitoring purposes only

I describe my ethnic background as: (please tick relevant box)

White

- | | |
|--|---|
| <input type="checkbox"/> English/Welsh/Scottish/Northern Irish/British | <input type="checkbox"/> Irish |
| <input type="checkbox"/> Gypsy or Irish Traveller | <input type="checkbox"/> Any Other White background |

Mixed/Multiple Ethnic Group

- | | |
|--|---|
| <input type="checkbox"/> White and Black Caribbean | <input type="checkbox"/> White and Black African |
| <input type="checkbox"/> White and Asian | <input type="checkbox"/> Any Other Mixed/Multiple Ethnic background |

Asian/Asian British

- | | | |
|----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Indian | <input type="checkbox"/> Pakistani | <input type="checkbox"/> Bangladeshi |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Any Other Asian background | |

Black/African/Caribbean/Black British

- | | |
|--|------------------------------------|
| <input type="checkbox"/> African | <input type="checkbox"/> Caribbean |
| <input type="checkbox"/> Any Other Black/African/ Caribbean background | |

Other Ethnic Group

- | | |
|-------------------------------|---|
| <input type="checkbox"/> Arab | <input type="checkbox"/> Any Other Ethnic Group |
|-------------------------------|---|

Age group:

- | | | | | | | |
|---------------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|------------------------------|--|
| <input type="checkbox"/> 25 and under | <input type="checkbox"/> 26-34 | <input type="checkbox"/> 35-44 | <input type="checkbox"/> 45-54 | <input type="checkbox"/> 55-64 | <input type="checkbox"/> 65+ | <input type="checkbox"/> Prefer not to say |
|---------------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|------------------------------|--|

The capture of this data is a requirement of both Ofsted and CQC, and as a College we have to provide data of our learner cohort.



Equal Opportunities continued

For monitoring purposes only

How would you define your gender:

<input type="checkbox"/> Man	<input type="checkbox"/> Woman	<input type="checkbox"/> Prefer not to say
<input type="checkbox"/> Other (Please specify)		

Marital status:

<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Civil Partnership	<input type="checkbox"/> Separated
<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced	<input type="checkbox"/> Prefer not to say	

Gender Identity. Do you now present full or part time in a gender role that differs from the gender assigned to you at birth?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prefer not to say
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Disability. Are you a disabled person, or do you have a medical condition such as epilepsy; diabetes; a mental health difficulty such as depression, or a specific learning disability such as dyslexia?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prefer not to say
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Sexual orientation

<input type="checkbox"/> Lesbian or gay	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Straight	<input type="checkbox"/> Prefer not to say
<input type="checkbox"/> Applicant does not have the capacity			
<input type="checkbox"/> Other (Please specify)			

Religion or belief

<input type="checkbox"/> Christian	<input type="checkbox"/> Muslim	<input type="checkbox"/> Buddhist	<input type="checkbox"/> Sikh
<input type="checkbox"/> Hindu	<input type="checkbox"/> Jewish	<input type="checkbox"/> None	<input type="checkbox"/> Prefer not to say
<input type="checkbox"/> Other (Please specify)			

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