Further Education Learner Application Form

Please place photograph of learner here

If submitting by Email, please attach JPEG

Learner name:

School name: (if appropriate)

Name of person completing this form and relationship to learner:

Date place required from:

Type of placement required:

Day

Residential

www.portland.ac.uk

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 Education Health Care Plan (EHC plan) if you have one.

If any of the information requested is included in your EHC plan, please feel free to leave the question blank.

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 assessment team will contact you to arrange an assessment here at the College, or where ever you feel most comfortable.

After this assessment, we will contact you to offer a placement (subject to funding) should our Multi Disciplinary Team feel that we can support you and your needs. Should this offer be accepted, 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 this funding has been accepted 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 has been designed to meet your specific individual requirements. We offer Day Centre Services, Independent Living Programmes and Short-Stay Breaks 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)

- Hospitality and Catering
- Art, Media and ICT
- Horticulture and Animal Care
- Administration and Events
- Retail
- Sport, Leisure and Fitness
- Duke of Edinburgh
- Communication and Life Skills (Pre-entry)

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.

Please tick here if this information is included in your enclosed EHC Plan

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:

Numeracy:

Information Technology:

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

Behaviour

Please describe some examples of any challenging behaviours that may affect your learning and others.
(please include all levels 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

Please tick here if this information is included in your enclosed EHC Plan ☐

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	☐ Yes	☐ No
Showering/bathing	☐ Yes	☐ No
Dressing	☐ Yes	☐ No
Grooming	☐ Yes	☐ No
Eating and drinking	☐ Yes	☐ No

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

Making a cold drink	☐ Yes	☐ No
Making a hot drink	☐ Yes	☐ No
Making a snack	☐ Yes	☐ No
Making a meal	☐ Yes	☐ No
Cleaning	☐ Yes	☐ No
Laundry	☐ Yes	☐ No
Shopping	☐ Yes	☐ 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:

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 leave 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

- English/Welsh/Scottish/Northern Irish/British
- Irish
- Gypsy or Irish Traveller
- Any Other White background

Mixed/Multiple Ethnic Group

- White and Black Caribbean
- White and Black African
- White and Asian
- Any Other Mixed/Multiple Ethic background

Asian/Asian British

- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any Other Asian background

Black/African/Caribbean/Black British

- African
- Caribbean
- Any Other Black/African/ Caribbean background

Other Ethnic Group

- Arab
- Any Other Ethnic Group

Age group:

- 25 and under
- 26-34
- 35-44
- 45-54
- 55-64
- 65+
- 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:

- Man
- Woman
- Prefer not to say
- Other (Please specify)

Marital status:

- Single
- Married
- Civil Partnership
- Separated
- Widowed
- Divorced
- 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?

- Yes
- No
- Prefer not to say

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?

- Yes
- No
- Prefer not to say

Sexual orientation

- Lesbian or gay
- Bisexual
- Straight
- Prefer not to say
- Other (Please specify)

Religion or belief

- Christian
- Muslim
- Buddhist
- Sikh
- Hindu
- Jewish
- None
- Prefer not to say
- Other (Please specify)

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