

Please place photograph of learner here

FURTHER EDUCATION LEARNER APPLICATION FORM

Learner name:

Preferred to be known as:

School name: (if appropriate)

Name and Signature of person completing this form and their relationship to learner:

Date form completed:

Date placement required from:

Type of Education placement required:



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 and 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
Primary Contact Person	
Name:	Relationship:
Address:	
Telephone: M	obile:
Email:	
Emergency contact? Yes No	
Parental Responsibility? Yes No	
If No to either of these questions, please provide det	tails of who is:
Please tick here if you would NOT like to be con or text regarding College events and promotion	
GP Contact	Surgeon #
Doctors name: Address:	Surgery:
Address.	
Tolophono:	
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 A	uthority	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.

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INFORMATION ABOUT YOU continued

What would you like to study at Portland College?

Please choose **one** study programme and also the subjects within the programme that interest you.



Communication and Choice (Pre-entry)

If you are working at pre-entry level, there will be a range of session topics for you to choose from when you arrive at college.

INFORMATION ABOUT YOU continued

What are your future aspirations?

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

Yes No

If yes, please provide details, including whether this was at school or with a company:

EDUCATIONAL DETAILS

You may wish to ask your school to help you complete this page.

What have you achieved so far?

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

What else have you achieved? (e.g. communication, decision making, problem solving, Duke of Edinburgh etc)

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

What are your current levels in the following areas: (If you do not know this, them please ask your school contact)

English:

Maths:

Vocational Areas:

Please let us have any certificates you have achieved so far with this application.

CONSENT AND BEST INTEREST DECISIONS

We now require parental consent to access confidential information around academic levels and accessing the most recent Education Health and Care Plan (EHCP) information from your local authority.

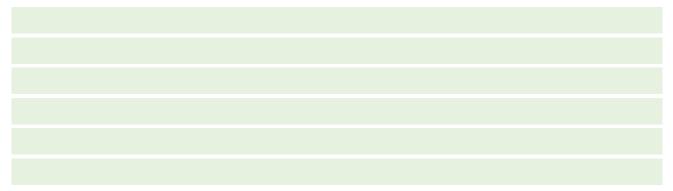
I consent to my son/daughter's EHC Plan and academic levels to be shared with the Assessment Triage Team at Portland College during the assessment process. The college's privacy statement can be found on our website: **www.portland.ac.uk**

Name of Learner:
Date of Birth:
Parent/Carer Name:
Relationship to Learner:
Date:
Signature:

Have there been any Best Interest decisions already made on behalf of the applicant?

Yes No

If YES, please state below for what decision (e.g. personal care, financial, medication.)



BEHAVIOUR

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

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	Occasiona	ally 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?

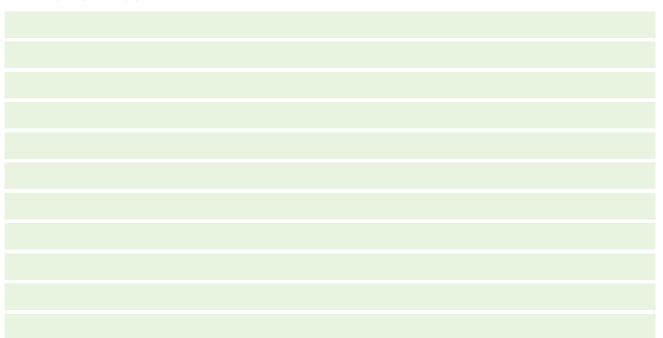
What helps staff to motivate you to stop the behaviours happening? (how do you like to be supported?)

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 Adolescent Mental Health Services, Psychology, and Treatment Team)		-	
If the answer is yes to the above question, please	e 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:



SAFEGUARDING 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, online interactions, being a trigger for others

Absconding - risks associated with absconding from different environments

Are there any current or historic safeguarding concerns we need to be aware of?

If you do not want to document any of these concerns would you like a phone call discussion with a member of the Safeguarding team?

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COMMUNICATION

Are you currently seeing a Speech and Language Therapist?	Yes	No
Is Speech and Language Therapy (SLT) named in your EHC Plan?	Yes	No
Have you got an individual communication plan?	Yes	No
If yes , please ensure you enclose a copy of this.		

What are you currently seeing a Speech and Language Therapist for? (e.g. speech, using signing)

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

Do	Do you have difficulties understanding: (please tick all those that apply)				
	Spoken Language				
	What is happening around you				
Plee	ase give any details:				
Do	any of the following things help you	u to	understand: (please tick all th	nat d	(ylqqp
	Objects		Photos		Pictures
	Symbols		Signing		Single Words
	Short Sentences				
Please give any details:					
Нον	w do you express yourself or get you	Jr m	essage 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

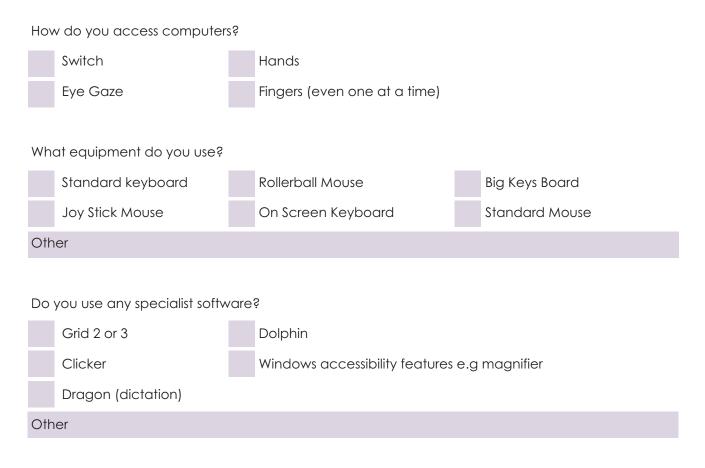
How do you access your Communication Aid?

	Eye Gaze
	Switch (Head/foot)
	Head Pointing
	Direct Access (touch)
ls th	is effective?
	Yes No
lf no	o, 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



EATING & DRINKING - MEAL TIME SUPPORT

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:	
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)	š,
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)	I
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)	

OCCUPATIONAL THERAPY

Please complete all questions in this section, even if you haven't had previous Occupational Therapy input.				
Please tick here if Occupational Therapy is named in your EHC Plan.				
Do you currently have, or have you previously received Occupational Therapy Support?				
Yes				
If yes, what for? Please provide contact details for your Occ	cupa	itional Therapi	st:	
Equipment				
Do you require specialist classroom seating?		Yes		No
Do you require any adapted toileting equipment?		Yes		No
If you answered yes to either of the previous questions, plea	ase p	rovide details:	:	
	10			
Does this equipment belong to you or your current placeme	ient?			
Do you currently use any other adapted equipment? Pleas	se de	tail below:		
Sensory				
Do you have any sensory processing difficulties that may af liking/needing lots of touch, movement, noise, etc?)	ffect	your learning?	? (e.	g. not
		Yes		No
If yes, please provide details below and complete the Sens	sory C	Choice Check	list.	
Do you require any sensory equipment (e.g. ear defenders,	. fida	et items etc.)3	;	
	,	Yes		No
If yes, please provide details below.				
Do you have any existing sensory strategies (e.g. movement be	preaks	, prompt cards Yes	s, de	ep pressure etc.)? No
If yes, please provide details below.				

SENSORY CHOICES CHECKLIST

Below are some questions related to each of the body's senses - please answer these and give as much detail as you are able.

There are also some activities listed that many people use daily to keep themselves **calm** or **alert**.

Please mark anything you like with a $\sqrt{}$ and anything you dislike with an X. Then mark the items you find calming with a C.

TASTE

Could you be described as a 'picky eater'?	Yes	No	
Do you chew or put inedible items in your mouth?	Yes	No	
Do you dislike the feel of things in your mouth? e.g toothbrush, certain textured food.	Yes	No	

Further details/comments:

Activities:

Drinking through a straw	Drinking through a sports bottle
Sucking inside of cheeks	Sucking/licking/biting lips
Grinding teeth	Clenching jaw
Crunching/sucking ice	Crunching crispy foods
Chewing gum	Chewing a toothpick
Chewing a chewy sweet	Chewing pen/pencil
Chewing clothing	Biting nails/hair
Blowing bubbles	Whistling
Sucking on a lollypop	

SMELL

Do every day smells affect you? e.g. petrol smells, food smells.	Yes	No
Do you smell objects/others?	Yes	No
Further details/comments:		

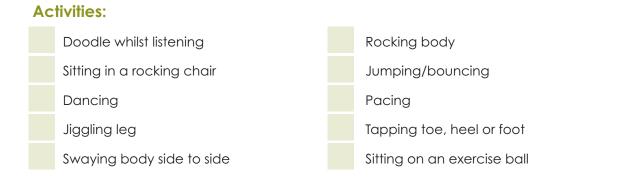
Activities:

Lavender	Aromatherapy
Smelly pens/stickers	Animals
Grass	Strong food smells (e.g. curry, fried food)
Sweet / citrus food smells	Perfume

MOVEMENT

Do you experience motion sickness?	Yes	No	
Do you seek out movement? e.g. can't sit still, fidgets, rocks, paces.	Yes	No	

Further details/comments:



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TOUCH

Do you regularly touch people and objects?	Yes	No
Do you dislike being touched?	Yes	No
Further details/comments:		

Activities:

Twiddling hair	Fiddling with objects (e.g. pen)
Being tickled	Having a massage
Having hair washed	Touching fluffy/velvety fabric
Stroking an animal	Tight fitted clothing
Playing in a sand pit	Water play
Picking at nails/skin	Pulling at clothes
Walking bare foot	Rubbing skin/clothing gently
Drumming fingers or pencil	

BODY AWARENESS

Do you bump into stationary objects? e.g walls, doors, lampposts.	Yes	No
Do you seek out activities that involve deep pressure?	Yes	No
Do you walk with heavy steps?	Yes	No
Are you aware of when you are in pain?	Yes	No
Do you know when you are too hot or cold?	Yes	No

Further details/comments:



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SIGHT

Do you have difficulty adapting to bright light more than others? (e.g. squint, cover eyes in daylight)?	Yes	No
Are you easily distracted by watching objects or people move around a room?	Yes	No
Do you seek visual stimuli, e.g. looking at lava lamp, fibre optic lights, dim lighting in dark spaces etc?	Yes	No
Further details/comments:		

HEARING/NOISE

Do you respond emotionally/aggressively to unexpected or loud noises?	Yes	No
Are you overly affected by background noise?	Yes	No
Further details/comments:		

Activities:

Make noise for noise sake	Noise making items
Wearing headphones to listen to music	Hearing thunder
Time in a quiet space	Wearing headphones/ear defenders/ ear plugs to block out noise
Covering ears with hands	Listening to music
Hearing alarm	

Fine Motor

Do	Do you have any difficulties related to your fine motor skills?						No
If yes, please provide details:							
Zips Handwriting Buttons Shoelaces				Shoelaces			
Using cutlery Other Classroom activities (including cooking)							

Do you have any adapted equipment/garments to help you to complete everyday activities (e.g. adapted cutlery, writing slope, pen grips, Velcro shoes etc.)?

Travel Training

Do you have any previc	aining?		Yes	No		
Do you feel that you would be able to travel independently in the near fut					Yes	No
Are there any risks or concerns about accessing the community?					Yes	No
Do you have any difficulties with the following skills:						
Road safety	Yes	No	Stranger danger		Yes	No
Money management	Yes	No	Time management		Yes	No
Problem solving	Yes	No				
If answered yes to any c	of these que	stions, please	provide further details:			
Residential Applicants C	only					
Do you require any equi	pment to su	pport with ac	tivities of daily living (e.g. sho	owe	r chair,	sleep
system etc)?					Yes	No
If yes please provide de	tails, includir	ng if you will b	e bringing the equipment w	ith y	ou to c	ollege:
Do you require support with activities of daily living (e.g. brushing teeth, doing laundry, cooking a meal etc)?						
Please detail any areas	you would li	ke to work on	:			
Road safety Money management Problem solving If answered yes to any of Residential Applicants C Do you require any equi system etc)? If yes please provide de Do you require support w meal etc)?	Yes Yes Yes of these que Only ipment to su tails, includir	No No No stions, please pport with ac ng if you will b	Stranger danger Time management provide further details: tivities of daily living (e.g. sho e bringing the equipment w	ith y	Yes r chair, Yes ou to c ndry, co	sleep No ollege:

PHYSIOTHERAPY

Do you have phy	ysiotherapy	named in your EHC Plar	n\$	Yes	No
If you are curren	tly seeing a	Physiotherapist please p	provide their contact	details:	
How do you usua	ally get arou	und?			
Do you need ass	istance to ge	et around? (e.g pushing	of wheelchair, supervis	sion when wa	lking/driving)
Yes	No				
lf yes, please pro	vide details	:			
Current physioth	erapy goals	s or things to work towar	ds:		
Equipment					
	equipment	to help you get around	other than a wheelch	nair?	
Do you use any o	equipment	to help you get around Stick			
Do you use any of Orthotics	equipment	Stick	other than a wheelch Standing Fram		
Do you use any of Orthotics Trike		Stick Walking Frame	Standing Fram	e	
Do you use any of the orthotics of the o	ne above, a	Stick	Standing Fram quipment not listed, pl	e Iease detail b	elow,
Do you use any of the orthotics of the o	ne above, a	Stick Walking Frame or if you use any other ea	Standing Fram quipment not listed, pl	e Iease detail b	elow,
Do you use any of the orthotics of the o	ne above, a	Stick Walking Frame or if you use any other ea	Standing Fram quipment not listed, pl	e Iease detail b	elow,
Do you use any of Orthotics Trike	ne above, a vill be bringi	Stick Walking Frame or if you use any other ea	Standing Fram quipment not listed, pl nt with you to college.	e lease detail b	elow,
Do you use any of Orthotics Trike	ne above, a vill be bringi	Stick Walking Frame or if you use any other ea ing any of this equipmer	Standing Fram quipment not listed, pl nt with you to college.	e lease detail b	elow,
Do you use any of Orthotics Trike If yes to any of the including if you want Would you be interval.	ne above, a vill be bringi terested in e No	Stick Walking Frame or if you use any other ea ing any of this equipmer	Standing Fram quipment not listed, pl nt with you to college ions during College he	e lease detail b bliday time?	
Do you use any of Orthotics Trike If yes to any of the including if you ver Would you be inter Yes If relevant, would	ne above, a vill be bringi terested in e No	Stick Walking Frame or if you use any other ea ing any of this equipmer	Standing Fram quipment not listed, pl nt with you to college ions during College he	e lease detail b bliday time?	
Do you use any of Orthotics Trike If yes to any of the including if you way Would you be inter Yes If relevant, would orthotics team?	ne above, a will be bringi terested in e No d you like ya	Stick Walking Frame or if you use any other ea ing any of this equipmer	Standing Fram quipment not listed, pl nt with you to college ions during College ho	e lease detail b bliday time?	

MOBILITY

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

Do you need any equipment or assistance to transfer?



If yes, please provide details:

PAIN

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

Where	is	iţŚ
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10	11 7

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:						

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)
Plea	ase 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 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:	105	
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?

If yes, please enclose the original documentation.

Yes

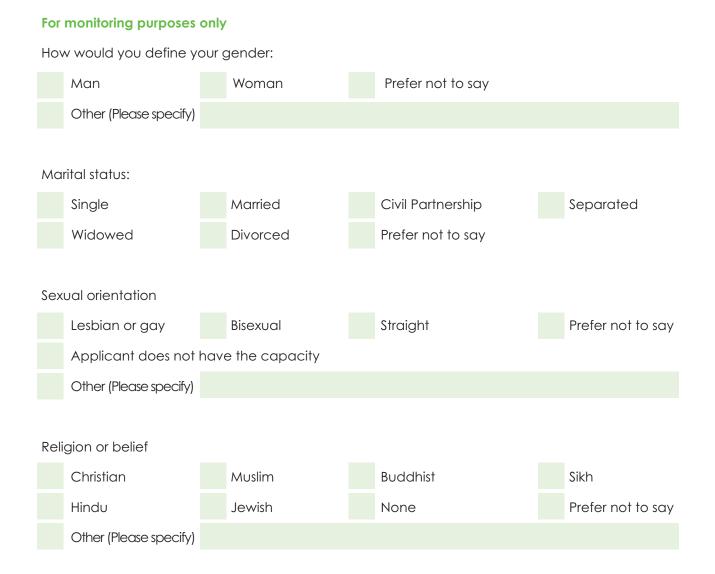
No

EQUAL OPPORTUNITIES



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EQUAL OPPORTUNITIES continued



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