FURTHER EDUCATION LEARNER APPLICATION FORM

Portland College

Learner name:

Prefers to be known as:

School name: (if appropriate)

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

Date form completed:

Academic year:

Type of Education placement required:

Day Placement (3 Day)

- [ ] Mansfield
- [ ] Forest Road West, Nottingham
- [ ] Woodborough Road, Nottingham

Residential Placement - Mansfield

- [ ] 5 day (Monday to Friday, term time)
- [ ] 7 day (Monday to Sunday, term time)
- [ ] 52 weeks a year

FOR OFFICE USE ONLY

Date received:

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, EHC plan and any other supporting documentation, including **educational certificates,** we 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 conditional placement. The offer is subject to funding being agreed by your local authority and EHCP status. 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.

For more information, please contact the Admissions team on **01623 499111** or email **admissions@portland.ac.uk**

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: Mobile:

Email:

Emergency contact? ☐ Yes ☐ No

Parental Responsibility? ☐ Yes ☐ No

If No to either of these questions, please provide details of who is:

GP Contact

Doctors name: Surgery:

Address:

Telephone:

Religious or Cultural needs:

NHS number:

Medical Exemption number:

☐ Please tick here if you would like to be contacted via email or text regarding College events and promotions

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

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

What is your disability?

How does it affect your learning?

INFORMATION ABOUT YOU continued

What would you like to study at Portland College?

Please choose **two** options of study programme and also the subjects within the programme that interest you.

- [ ] **Land Based and Trade Industries**
  - [ ] Horticulture
  - [ ] Small Animal Care
  - [ ] Light Manufacturing
  - [ ] Production and Logistics
  - [ ] Painting and Decorating
  - [ ] Basic Joinery
  - [ ] Basic Wet Trade Skills
  - [ ] Motor Vehicle Mechanic
- [ ] **Design, Technology and Retail Industries**
  - [ ] Business Studies, Retail and Administration
  - [ ] Arts, Media and Marketing
  - [ ] Customer Services
  - [ ] E-Sports and Games Development
- [ ] **Service and Leisure Industries**
  - [ ] Sport and Leisure
  - [ ] Hospitality and Catering
  - [ ] Health and Social Care
  - [ ] Salon Services
- [ ] **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.

* Programmes may be subject to change depending on application numbers.

INFORMATION ABOUT YOU continued

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:

What are your future aspirations?

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/ Pre-entry)	Grade/ Expected Grade

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

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:

CONSENT AND BEST INTEREST DECISIONS

We now require learner (where applicable) and/or parent/carer 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 being shared with the Admissions 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 any Best Interest, Power of Attorney, Deputyship, Guardianship decisions been made on behalf of the applicant?

☐ Yes ☐ No

If YES, please state below for what decision and include any relevant documentation.

BEHAVIOUR

Please describe examples of any behaviours that may challenge 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

When was the last occurrence of behaviour?

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:

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?

Would you like a phone call to discuss anything further with a member of the Safeguarding Team?

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 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 continued

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

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)

Do you use any devices to support your learning?

- ☐ Laptop
- ☐ iPad
- ☐ Tablet
- ☐ Mobile Phone

Do you use any apps/functions to support your reading/writing/spelling?

- ☐ Dictation
- ☐ Spoken Content
- ☐ Microsoft Lens
- ☐ Predictive Text

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

What assistive equipment software/hardware have you used before or would be interested in trying?

- [ ] Standard Keyboard
- [ ] Big Keys Board
- [ ] On Screen Keyboard
- [ ] Adaptive Switches
- [ ] Any Microsoft Accessibility Function
- [ ] Pictello/Book Creators
- [ ] Reading Pen
- [ ] Rollerball Mouse
- [ ] Joy Stick Mouse
- [ ] Standard Mouse
- [ ] Voice Recognition Software/Dictation
- [ ] Clicker
- [ ] MyStudy Bar
- [ ] Seeing AI

Other

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?

Easy to chew Soft & bite sized Minced & moist

Pureed Liquidised

Any other details?

Please provide a copy of your Eating & Drinking Guidelines if applicable.

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

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.

Have you previously received Occupational Therapy Support?

☐ Yes ☐ No

If yes, what for? Please provide contact details for your Occupational Therapist:

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, please provide details:

Does this equipment belong to you or your current placement?

Do you currently use any other adapted equipment? Please detail below:

Sensory

Do you have any sensory processing difficulties that may affect your learning? (e.g. not liking/ needing lots of touch, movement, noise, etc?)

☐ Yes ☐ No

If yes, please provide details below and complete the **Sensory Choice Checklist.**

Do you require any sensory equipment (e.g. ear defenders, fidget items etc.)?

☐ Yes ☐ No

If yes, please provide details below.

Do you have any existing sensory strategies (e.g. movement breaks, prompt cards, deep pressure etc.)?

☐ Yes ☐ No

If yes, please provide details below.

OCCUPATIONAL THERAPY continued

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

OCCUPATIONAL THERAPY continued

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

Activities:

- ☐ Doodle whilst listening
- ☐ Sitting in a rocking chair
- ☐ Dancing
- ☐ Jiggling leg
- ☐ Swaying body side to side
- ☐ Rocking body
- ☐ Jumping/bouncing
- ☐ Pacing
- ☐ Tapping toe, heel or foot
- ☐ Sitting on an exercise ball

OCCUPATIONAL THERAPY continued

TOUCH

Do you regularly touch people and objects? Yes ☐ No ☐

Do you dislike being touched? Yes ☐ No ☐

Further details/comments:

Activities:

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

BODY AWARENESS

Have you had any previous falls? Yes ☐ No ☐

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:

Activities:

- ☐ Yoga
- ☐ Walking along balance beams
- ☐ Throwing and catching a ball
- ☐ Hop scotch
- ☐ Using weighted equipment
- ☐ Walking along stepping stones
- ☐ Kicking a ball
- ☐ Boccia

OCCUPATIONAL THERAPY continued

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

OCCUPATIONAL THERAPY continued

Fine Motor

Do you have any difficulties related to your fine motor skills? Yes ☐ No ☐

If yes, please provide details:

☐ Zips ☐ Handwriting ☐ Buttons ☐ Shoelaces

☐ Using cutlery ☐ Other Classroom activities (including cooking)

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

Travel Training

Do you have any previous experience of Travel Training? Yes ☐ No ☐

Do you feel that you would be able to travel independently in the near future? Yes ☐ No ☐

Are there any risks or concer ns 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 of these questions, please provide further details:

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:

PHYSIOTHERAPY

Do you have physiotherapy named in your EHC Plan? Yes ☐ No ☐

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:

Current physiotherapy goals or things to work towards:

Equipment

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

☐ Orthotics ☐ Stick ☐ Standing Frame

☐ Trike ☐ Walking Frame

If yes to any of the above, or if you use any other equipment not listed, please detail below, including if you will be bringing any of this equipment with you to college.

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?

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?

Please provide a copy of your current epilepsy plan.

☐ 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 (including support plans), plus any other relevant medical history:

Do you have any continence needs? ☐ Yes ☐ No

If yes, please provide detail:

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 original packaging, ensuring all details are clearly labelled with the recipient's name.

We cannot administer medication if it is not in the original 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

Please only complete this page if you are applying for a residential place.

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 Residential Care 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.

SLEEPING, DRESSING AND UNDRESSING

Please complete this section if you are applying for a residential 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:

Do you need turning at night? Yes ☐ No ☐

Do you need to have early nights? Yes ☐ No ☐

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?

Do you require any equipment to support with activities of daily living (e.g. shower chair, sleep system etc)? Yes ☐ No ☐

If yes please provide details, including if you will be bringing the equipment with you to college:

Do you require support with activities of daily living (e.g. brushing teeth, doing laundry, cooking a meal etc)? Yes ☐ No ☐

Please detail any areas you would like to work on: