![Diagram

Description automatically generated]()

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of referral** |  | | **Young person aware of referral?** | | | | Yes/No |
| **Person making referral** | |  | | **Contact Details** | |  | |
| **Organisation** |  | | **Email** | |  | | |
| **Reason for Referral** |  | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Young Person Details** | | | | | |
| Name |  | | DOB | |  |
| Address |  | | | | |
|  | | | | |
|  | Postcode | |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent/Carer Details** | | | |
| Parent/Carer 1 |  | Home |  |
| Email |  | Mobile |  |
| Address |  | | |
| Parent/Carer 2 |  | Home |  |
| Email |  | Mobile |  |
| Address |  | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Sensory Information** | | | | | | | | | | |
| Deaf |  | Hard of hearing | | |  | Hearing | |  | Deafblind |  |
| **Communication preference** | | | | | | | | | | |
| BSL user | | |  | SSE user | | |  | Lip reader | |  |
| English | | |  | Other | | |  | | | |
| **Assistive Technology** | | | | | | | | | | |
| Hearing Aid | | |  | Cochlear Implant | | |  | Bone Conduction | |  |
| Middle Ear Implant | | |  | Auditory Brainstem Implant | | |  | None | |  |
| Other | | |  | | | | | | | |
| Additional Information | | |  | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Would like further information about… (please tick all that apply)** | | | | | | | |
| **Family Groups** (including: Happy Hands, social groups, peer support for adults, family activities) |  | **Family Sign language** |  | **Equipment** |  | **Advocacy** |  |
| **Youth Groups** |  | **Deaf Awareness** |  | **Volunteering** |  | **Other** |  |
| **I CAN project** (support for children, young people and families) |  | **Peer mentor/ buddy support** (for children and young people) |  | **Fundraising support** |  |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **OFFICE USE ONLY** | | Date Received | |  | | Method |  | | |
| Referred to |  | | Contact with family made | | Yes/No | | | Date |  |

**Please return the completed from to ICAN@deafnessresourcecentre.org or mail to: Children, Young people and family Deafness Resource Centre, 32-40 Dentons Green Lane, St Helens, WA10 2QB**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medical Information** | | | | | |
| Does your child have any known medical conditions or disabilities? |  | | | | |
| Does your child have any know allergies? |  | | | | |
| Last tetanus injection |  | | | | |
| Doctor name |  | Phone Number | |  | |
| Doctors Address |  | | Postcode | |  |
| Does your child require additional support; either as a result of disability or through individual circumstances or preferences? Please let us know so that we can better plan for everyone to take part. | | | | | |
|  | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Education Information** | | | | | |
| Nursery Name |  | | |  |  |
| School Name |  | | | Year of start |  |
| In what year will your child enter | | High School |  | College |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Emergency Phone Numbers** | | | | | |
| Please list suitable contacts if you are unavailable in case of an emergency | | | | | |
| Name |  | Phone |  | Relationship |  |
| Name |  | Phone |  | Relationship |  |
| Name |  | Phone |  | Relationship |  |
| Name |  | Phone |  | Relationship |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Consent** (Complete appropriate) | | | | | |
| In the event that reasonable attempts to contact me at one of the numbers provided have been unsuccessful, I hereby give my consent for:   1. The administration of any treatment deemed necessary by a doctor or dentist 2. The transfer of my child to hospital | | | | | |
| Name |  | Signed |  | Date |  |
| I do not give my consent for emergency medical treatment of my child. In the event of any illness or injury requiring treatment, I wish DRC to take no action or to: | | | | | |
| Name |  | Signed |  | Date |  |

**Photo / Video Permission Form**

At the DRC we would like to take photographs/videos of the group which could include yourself and/or your child(ren).

We may wish to include these photographs/videos in future promotional material such as leaflets, Facebook pages, websites etc.

Could you please indicate if we have permission to use yours and/or you child’s photographs/videos and where we may do so by completing the information below?

Thank you.

**Consent**

Please tick the appropriate boxes below

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| Deafness Resource Centre Website |  |  |
| Deafness Resource Centre Facebook – Public Page |  |  |
| Deafness Resource Centre Twitter |  |  |
| Deafness Resource Centre Instagram |  |  |
| Happy Hands Facebook – Closed Group |  |  |
| Happy Hands Facebook – Public Page |  |  |
| Happy Hands Twitter |  |  |
| Happy Hands Website |  |  |
| Deaf Active Facebook – Closed Group |  |  |
| Promotional Material |  |  |
| Newsletters |  |  |
| Other organisations (e.g. NDCS, Children in Need, Signature) |  |  |

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If appropriate)

Name of Child (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Child (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Child (3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to child (if appropriate): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CUSTOMER PRIVACY NOTICE**

Here at the **Deafness Resource Centre** we take your privacy seriously and will only use your personal information to administer your account and to provide the products and services you have requested from us.

The DRC will never share your personal data with third-parties without your consent. Your data will be stored and disposed of securely and only used for the purposes stated above.

If you agree to your personal data being processed as outlined above **please sign below to confirm consent.** You have a right to access your personal data at any time and consent to process the data can be withdrawn.

Failure to provide personal data may result in the DRC being unable to provide services or enter into an agreement with you.

From time to time we would like to contact you with details of other [products]/ [offers]/[services]/[competitions] we provide. If you consent to us contacting you for this purpose please tick to say how you would like us to contact you:

Post ☐ Email ☐ Telephone ☐ Text message ☐

Signed:……………………………………………….

PRINT name:

Date:

Deafness Resource Centre Ltd

32-40 Dentons Green Lane

St Helens WA10 2QB

Data Protection Lead – **Chief Officer**

Contact details: telephone **01744 23887**

Email: [helen.fitzgerald@deafnessresourcecentre](mailto:helen.fitzgerald@deafnessresourcecentre).org

Further guidance: ICO.org.uk