Membership Form

Personal information - We respect your privacy and are committed to ensuring that we protect your details. However, so that we can support you in the best way we can, we may need to share some information with the local authority and other agencies and organisations.

Your Name ____________________

Date of Birth ____ / ____ / ______ Gender ____________

Home Address ____________________

____________________ Post Code ____________

Email Contact YOUNG PERSON

PARENT / CARER

Home Telephone ____________ Mobile YOUNG PERSON Mobile PARENT / CARER

IN CASE OF AN EMERGENCY

I would like you to contact ____________________

Who is my: Mum ☐ Dad ☐ Carer ☐

Telephone HOME

Mobile PARENT / CARER

PLEASE ATTACH PHOTO OF YOUNG PERSON

ANY ALLERGIES

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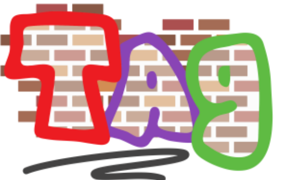
TREATMENT CONSENT

I give my consent for the named person on this form to receive any medical treatment deemed necessary in the event of an incident occurring.

SIGNATURE

NAME & DATE



About Me

My Diagnosis

Additional Needs

How I Communicate

Things That Distress Me

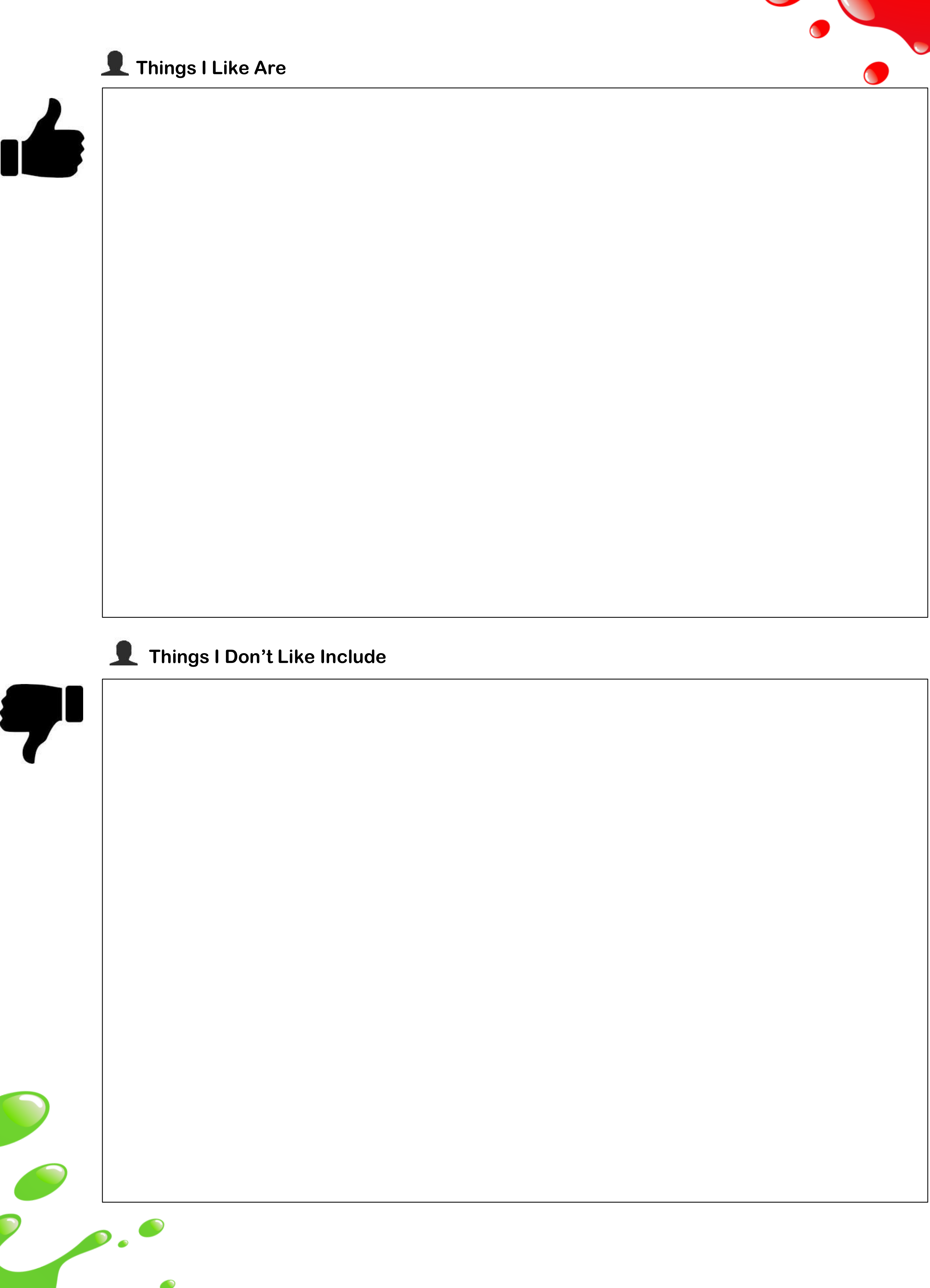
What I Do When Distressed

How Best To Manage My Distress

Absconding Risk YES ☐ NO ☐

Support I May Need

Additional Information



Things I Like Are

Things I Don't Like Include

My Doctor's Name

Surgery Address

Post Code

Telephone

Medication

Dosage

Instructions

Medication

Dosage

Instructions

Medication

Dosage

Instructions

Anything Else You Would Like To Let Us Know About

Thank you for completing our membership form, please sign the declaration below:

Name

Signature

Date

IMPORTANT IF YOU ARE UNDER 18, YOUR PARENT OR CARER ALSO NEEDS TO SIGN THIS FORM

Name

Signature

Date