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**Take That Project**

**Referral Form**

Please Return to Linda@localaid.co.uk

Or post to Local Aid 70 High St Gorseinon Swansea SA44BP

**This form is available in Welsh, and in other languages and formats on request./Mae’r cyhoeddiad hwn ar gael yn Gymraeg, ac mewn ieithoedd a fformatau eraill ar gais.**

**Participant Eligibility Criteria**

The project aims to give young people a meaningful work experience placement, gaining new skills, opportunities and experiences in a live warehouse/retail enviroment. This will then enhance the prospects of future employment for the young people and they will also gain access to Agored Cymru (OCN) accredited training.

The project will do this by hosting work placements in our charity shop for young adults, age 15 to 25, where they will be supported by paid staff and volunteers.

Services are available to young people who have additional learning needs/disengaged in education/challenging behaviour/socially excluded (or at risk of). Young people must be aged 15 -25 years when they are referred to/enrolled with the project.

**Local Aid’s Take That Project Referral Form**

**Please complete all forms.**

The responses given on this form will be crucial in deciding as to the appropriateness of the referral for the Project. It is essential that this form is filled out with the young person and their parent/carer.

|  |  |
| --- | --- |
| Date of referral: |  |

## Young Person’s details:

|  |  |  |  |
| --- | --- | --- | --- |
|  | First name | Surname | Date of birth |
| **Young person’s name:** |  |  |  |
| **Name young person likes to be known by** |  |
| **Address:** |  |
| Post code: |  | **Telephone no.** |  |
| **Mobile No.** |  |
| Email: |  |
| Mother’s name |  |
| **Father’s name** |  |
| **Who has parental responsibility? (if required)** |  | **Emergency Contact Name & Number** |
| **Next of Kin** |  |  |
| **Main carer/****Key worker** |  |
| School/College |  |
| **G.P. & Practice** |  |
| **What is the language you use at home?** |  |
| **In what language would you prefer to communicate with us?** |  |

**Referrer Details:**

|  |  |
| --- | --- |
| Name |  |
| Profession/Relation to |  |
| Address |  |
| **Tel No**. |  |
| Email |  |

|  |  |
| --- | --- |
| Does the young person have:Additional learning needs? | **YES [ ]  NO [ ]**  |
| A diagnosis of an Autistic Spectrum Disorder (including Asperger’s Syndrome)?A physical disabilityA sensory impairmentMental health problemsLong term care needsChallenging Behaviour Socially excluded (or at risk of)Disengaged in education  | **YES [ ]  NO [ ]** **YES [ ]  NO [ ]** **YES [ ]  NO [ ]** **YES [ ]  NO [ ]** **YES [ ]  NO [ ]** **YES [ ]  NO [ ]** **YES [ ]  NO [ ]** **YES [ ]  NO [ ]**  |
| Does (or did) the young person have a statement of special educational need?  | **YES** **[ ]  NO** **[ ]**  |
| Does (or did) the young person receives any extra help in school/college? | **YES** **[ ]  NO** **[ ]**  |
| **If “yes,” please describe** |  |
| Does the young person have a Social Worker or Care Manager?  | **YES** **[ ]  NO** **[ ]**  |
| **If “yes”, please give their name and contact details.** |  |
| Has the young person received input from any other health or education professionals, specifically: |  |
| Speech and language therapist?Occupational therapist?Hearing impairment/visual impairment service?Any other?**Please specify name and profession** | **YES [ ]  NO [ ]** **YES [ ]  NO [ ]** **YES [ ]  NO [ ]** **YES [ ]  NO [ ]**  |
|  |  |
|  |  |
|  |  |
| **Please give details of any other services, clubs or groups that the young person attends** |  |

## DEVELOPMENTAL AND MEDICAL HISTORY

Diagnosis/medical history:

Please include any diagnosed conditions and/or serious illnesses and/or injury in the last 2 years that the young person has had.

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……………………………………………………………………………………………………………………...

# Is the young person colour blind? **YES [ ]  NO [ ]  DON’T KNOW [ ]**

Does the young person have any allergies? **YES** **[ ]  NO** **[ ]**

Please state e.g. nut, latex, hay fever .………………………………………………………..

 Are the allergies intermittent or all the time? …..………………………………………..

# Does the young person have epilepsy? **YES** **[ ]  NO** **[ ]**

# Is epilepsy controlled by medication? **YES [ ]  NO [ ]**

# Seizures sometimes [ ]  No seizures for a long time [ ]

# Is the young person taking any medication at present? **YES** **[ ]  NO** **[ ]**

If yes, please list and explain what for.

1. ………………………………………………………………………………………………………….….
2. ……………………………………………………………………………………………….…………….
3. …………………………………………………………………………………………….……………….
4. …………………………………………………………………………………………….……………….

## Please list the main reasons for referral of the young person.

1. …………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………

2. ………………………………………………………………………………………………………………….….

…………………………………………………………………………………………………………………..…….

3. ………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………

Will the young person be using public transport to get to the work

placement?  **YES [ ]  NO [ ]**

Is the young person aware of road safety?  **YES [ ]  NO [ ]**

## Any other information you think we need to know

(e.g. triggers to challenging behaviour/aggression)

…………………………………………………………………………………………………………………....…..

………………………………………………………………………………………….………………………………

.…………………………………………………………………………………………………….………………….

I declare that the details given on this form are true to the best of my knowledge.

**Parent/carer signed: ……………………………………. ………**

**Relationship to young person: ……………………………………. ………**

**Young Person signed……………………………………. ………**

**Date: ………………………………………………………...**

**Thank you**

PLEASE Return to Linda@localaid.co.uk

Or post to Local Aid 70 High St Gorseinon Swansea SA44BP

**For office use only**

# Project criteria satisfied **YES [ ]  NO** [ ]

**Signed……………………………………….Date………………………………………….**

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**Training Registration Form**

THIS FORM NEEDS TO BE COMPLETED AT THE START OF EACH UNIT SO THAT THE LEARNER CAN BE REGISTERED WITH AGORED CYMRU.

Without registration we will not be able to recognise training or award credits.

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POST CODE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TELEPHONE NO:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-MAIL:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**UNIT BEING UNDERTAKEN:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**START DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **END DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYMENT STATUS:**

UNEMPLOYED / UNWAGED (NOT SEEKING WORK) / FULL TIME STUDENT / EMPLOYED

**ETHNIC ORGIN:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**D.O.B.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SEX:**  MALE / FEMALE

**Consent Form**

Name of young person:

Home Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Post code:

Tel number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Tel Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Second Emergency No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Family Doctor:

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tel No : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree that the young person named above may take part in all the activities and visits outlined in the programme plan.

I agree / do not agree for the young person to be photographed/ videos for recording achievements/media such as local press / charities own website.

I consent to person in charge in my absence to seek any emergency advice or treatment necessary during the visit/activity.

During the project there will be break/lunch time where your child may want to go out to get lunch/have a break outside. If young person is under 18 years old it parental choice whether or not you consent for your child to leave the premises during the project.

Please specify whether they are allowed off the premises whilst on the project:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We do not permit smoking on any of our premises. It is illegal under health and safety at work laws. Smokers must NOT smoke at entrances to any of our buildings where members of the public or colleagues pass through. Please do not smoke near the door of our offices or charity shops- walk away from all entrances and exits both back and front.

 I agree that the young person named above will not smoke on the premises

I therefore authorise the person in charge of the placement to sign on my behalf, any written form of consent required by the hospital authority should a surgical operation serum injection be deemed necessary and if the delay required to obtain my signature might be considered, in the opinion of the doctor or surgeon concerned, likely to endanger the young person/ young person’s health and safety.

The young person has/have allergic reactions to the following:

The young person has a diagnosis of:

Signed Parent/Guardian

Signed young person

Date

**CONSENT PERSONAL DATA**

I understand that the personal information collected by Local Aid will be held on file at the office & only shared with professionals for City and County of Swansea who are our main funders but will not passed on to any other parties without my prior consent. I understand that any information shared will be the minimum necessary.

I understand that this information will be held in accordance with the General Data Protection Regulations (GDPR) for a period of 7 years prior to completion of project/activity. I understand I have a right under the new GDPR to have access to all information held by Local Aid on request.

I am happy for a record of all the sessions I attend to be kept, to help the Local Aid run better services for young people in Swansea.

**Signed by young person if over 18 or Parent/Guardian if under 18:**

**Print name** ……………………………………….... **Signed** ………………..…………………… **Date**…………………………..….

**Please return all these forms at least one week before placement to:**

**Linda Wellington , 70 High St, Gorseinon, Swansea, SA4 5BLOR email completed forms to** **linda@localaid.co.uk**

**Look at the boxes below and circle the skills which the**

**young person would like help with.**

|  |  |
| --- | --- |
| **Customer Service Skills**Display merchandisePromoting merchandiseMoney HandlingUsing telephoneCustomer Care Organising donationsMentoringRetail**TAKE THAT** | **Marketing & publicity skills**Publicising the work of our charitySkillsWork experienceDesign, create and produce signs/leafletsUse Ebay to sellIT skills  |
| Greeting customersDecisionsSupportCommunicating with members of the publicListening to customers’ needsSelf-esteem/Emotional well beingHaving more confidenceLearning good social skills**Communication skills** | InformationTime managementBeing an ambassador of Local AidWorking on own initiativeGetting Agored Cymru qualifications**Additional skills**Voluntary work |