|  |  |  |  |
| --- | --- | --- | --- |
| Name of child   |   | Age |  |
| Name of parent/s   |   |
| Email address |  |
| Contact number |  |
| When would your child be looking to start?  |  |
| Are they currently at another setting and if so, where?  |   |
| How many hours are they there?  |  | Dual Placement? |  |
| Do they have social worker involvement? If so, who?  |   | Do they have an EHCP in place?  |  |
| Name of person who suggested TWOA? *This is generally a professional – contacting them is helpful for supporting the application* |   |
| Outline of needs – Medical     | Shunt  |  | Epilepsy |  | Oxygen |  |
| Primary Diagnosis e.g., Downs Syndrome |  |
|  |
| Outline of needs – Sensory Impairments    | Hearing  |  | Visual  |  |  |  |
|  |
| Outline of needs – Physical     |  Buggy |  | Wheelchair |  | CP |  |
|  |  |  |  |  |  |
|  |
| Outline of needs – Sensory     |  ASD |  | Sensory |  |  |  |
| Overload Easily i.e. Do they become dysregulated? |  |
|  |
| Outline of needs – Communication     |  Verbal |  | PECS |  | Sign |  |
| Any other form of communication? |  |
|  |
| Any restrictions of visit times? |   |
| Anything else we need to know?   |   |