



Member of the Association of Camphill Communities

Rhandirmwyn

Registered Charity No.: 502742

STUDENT APPLICATION FORM

Please complete and return to: Student Admissions
Coleg Elidyr
Rhandirmwyn
Llandovery
Carmarthenshire
SA20 0NL

Tel: 01550 760400
Fax: 01550 760331
e-mail: admin@colegelidyr.com

PRIVATE AND CONFIDENTIAL

PLEASE ENCLOSE A PHOTOGRAPH OF THE APPLICANT

Proposed date of entry:			
Name of person filling in this form:			
Relationship to applicant:			
APPLICANT'S DETAILS			
Full Name:			
Address:			
Telephone number:		Mobile number:	
Date of Birth:		Sex:	
Place of Birth:		National Insurance No.:	
Religious Persuasion:			

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EMERGENCY CONTACT DETAILS

Who is the primary contact in case of emergency?

Name	Telephone numbers
	Home:
	Work:
	Mobile:
	Other alternative, e.g. neighbours, grandparents, etc.

HOME & FAMILY



It is helpful to have an understanding the family circumstances of the applicant, e.g. parents are divorced/separated but both parties wish to receive correspondence. Please give us any information you think we need to know.

Title (Mr, Mrs, Miss, etc.)	Christian Name	Surname	Address As applicant? yes or no If no, please fill in details.
Relationship to applicant (e.g. mother, stepfather, guardian, etc.)		Occupation	
			 e-mail:
Title (Mr, Mrs, Miss, etc.)	Christian Name	Surname	Address As applicant? yes or no If no, please fill in details.
Relationship to applicant (e.g. mother, stepfather, guardian, etc.)		Occupation	
			 e-mail:
Title (Mr, Mrs, Miss, etc.)	Christian Name	Surname	Address As applicant? yes or no If no, please fill in details.
Relationship to applicant (e.g. mother, stepfather, guardian, etc.)		Occupation	
			 e-mail:

BROTHERS & SISTERS

Name	Date of Birth	Sex	Learning Disability?
1.			Yes <input type="checkbox"/> No <input type="checkbox"/>
2.			Yes <input type="checkbox"/> No <input type="checkbox"/>
3.			Yes <input type="checkbox"/> No <input type="checkbox"/>
4.			Yes <input type="checkbox"/> No <input type="checkbox"/>
5.			Yes <input type="checkbox"/> No <input type="checkbox"/>

PROFESSIONAL CONTACTS

Careers/Personal Adviser Name:	
Address:	
 e-mail:	
Social Worker Name:	
Address:	
 e-mail:	

DIAGNOSIS

Please give details.


LEARNING DISABILITIES

Please give details, including any incidents that could have contributed to the disability.



EDUCATION & TRAINING

Has the applicant ever been excluded from school?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If 'yes', on what grounds?
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School or college currently attended

Name: Type: (e.g. mainstream, LD) Headteacher/ Contact person: Address: 			
Start date:		Leaving date?	

Previous schools

Name:			
Type: (e.g. mainstream, LD)			
Address: 			
From:		To:	
Name:			
Type: (e.g. mainstream, LD)			
Address: 			
From:		To:	

PERSONAL CARE, etc.

1. Can the applicant care for his/her own hygiene?	
2. Is the applicant continent? If 'no', please give details.	
3. What level of support does the applicant need with personal care?	
4. Can he/she make the bed and care for his/her room?	
5. What is his/her relationship to personal property?	

CURRENT ABILITIES

1. Can the applicant read and write?	
2. Can he/she do any handiwork or craft?	
3. Can the applicant go shopping on his/her own?	
4. Can the applicant travel on his/her own?	
5. Can the applicant ride a bike?	
6. Can the applicant swim?	
7. Can the applicant play a musical instrument?	
8. Can the applicant occupy himself/herself during free time?	

MEDICAL AND OTHER INFORMATION

1. When did the applicant begin to walk?	
2. When did the applicant begin to talk?	
3. Does he/she have any physical disability/disabilities? If 'yes' , please give details.	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Does the applicant need any specialised equipment for mobility? If 'yes' , please give details.	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Does the applicant receive/need physiotherapy? If 'yes' , please give details.	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Please comment on the applicant's eyesight.	
7. Does he/she need to wear glasses?	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Please comment on the applicant's hearing.	
9. Does he/she need to wear a hearing aid?	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Please comment on the applicant's speech.	
11. Has the applicant had any speech therapy? If 'yes' , please give details.	Yes <input type="checkbox"/> No <input type="checkbox"/>
12. Does the applicant have any problems sleeping? If 'yes' , please give details.	Yes <input type="checkbox"/> No <input type="checkbox"/>
13. Does the applicant have any allergies? If 'yes' , please give details.	Yes <input type="checkbox"/> No <input type="checkbox"/>

14. Does the applicant have any food allergies? If 'yes' , please give details.	Yes <input type="checkbox"/> No <input type="checkbox"/>
15. Does the applicant need a special diet? If 'yes' , please give details.	Yes <input type="checkbox"/> No <input type="checkbox"/>
16. Does the applicant have any food dislikes? If 'yes' , please give details.	Yes <input type="checkbox"/> No <input type="checkbox"/>
17. Has the applicant ever had any injuries? If 'yes' , please give details (including dates)	Yes <input type="checkbox"/> No <input type="checkbox"/>
18. Has the applicant ever been in hospital? If 'yes' , please give details. (including dates)	Yes <input type="checkbox"/> No <input type="checkbox"/>
19. Is the applicant epileptic? If yes , are there any warning signs? How long does the seizure last? What medication is prescribed for epilepsy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
20. Has the applicant ever had any of the following? hay fever: Yes <input type="checkbox"/> No <input type="checkbox"/> asthma: Yes <input type="checkbox"/> No <input type="checkbox"/> mumps: Yes <input type="checkbox"/> No <input type="checkbox"/> measles: Yes <input type="checkbox"/> No <input type="checkbox"/> chicken pox: Yes <input type="checkbox"/> No <input type="checkbox"/> eczema: Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. Does the applicant have (or has he/she ever had) any other medical problems of which we should be aware? If 'yes' , please give details.	Yes <input type="checkbox"/> No <input type="checkbox"/>
22. Is the applicant currently consulting a specialist? If 'yes' , please give details.	Yes <input type="checkbox"/> No <input type="checkbox"/>
23. Does the applicant have (or has he/she ever had) any mental health problems? If 'yes' , please give details.	Yes <input type="checkbox"/> No <input type="checkbox"/>
24. Does the applicant see (or has he/she ever seen) a psychologist, psychotherapist or psychiatrist? If 'yes' , please give details.	Yes <input type="checkbox"/> No <input type="checkbox"/>
25. Please list all medication currently being taken (including dosage and strength) and any emergency medication, e.g. oral Diazepam.	

BEHAVIOURS

Does the applicant exhibit any of the following?

Please comment on the nature and frequency of the behaviour.

1. swearing	Yes <input type="checkbox"/> No <input type="checkbox"/>	
2. uncooperativeness	Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. moodiness	Yes <input type="checkbox"/> No <input type="checkbox"/>	
4. repetitive behaviour	Yes <input type="checkbox"/> No <input type="checkbox"/>	
5. screaming	Yes <input type="checkbox"/> No <input type="checkbox"/>	
6. absconding	Yes <input type="checkbox"/> No <input type="checkbox"/>	
7. soiling/wetting/vomiting	Yes <input type="checkbox"/> No <input type="checkbox"/>	
8. stripping/ripping clothes	Yes <input type="checkbox"/> No <input type="checkbox"/>	
9. spitting	Yes <input type="checkbox"/> No <input type="checkbox"/>	
10. damaging property	Yes <input type="checkbox"/> No <input type="checkbox"/>	
11. hitting/thumping	Yes <input type="checkbox"/> No <input type="checkbox"/>	
12. self-injurious behaviour	Yes <input type="checkbox"/> No <input type="checkbox"/>	
13. head butting	Yes <input type="checkbox"/> No <input type="checkbox"/>	
14. hair pulling	Yes <input type="checkbox"/> No <input type="checkbox"/>	
15. scratching/pinching	Yes <input type="checkbox"/> No <input type="checkbox"/>	
16. biting	Yes <input type="checkbox"/> No <input type="checkbox"/>	
17. playing with fire	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Has anyone been physically injured by any of the above behaviours?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If 'yes', please comment.
and		Please give details where necessary.
1. Can applicant distinguish between reality and fantasy?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
2. Is the applicant sexually aware?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Are there any inappropriate sexual behaviours of which we should be aware?	Yes <input type="checkbox"/> No <input type="checkbox"/>	

REPORTS, etc.			
Do you have.....?	Yes or No	If yes, is a copy enclosed with application form?	Copy to follow?
Recent School/College report	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recent Care & Education Plan	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School Review Report	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recent Risk Assessment	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Services Report	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Report from respite care or another residential home	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Statement of need	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychologist's report	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech therapy report	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ANY OTHER INFORMATION?

Declaration (by person responsible for application): *To the best of my knowledge, the information submitted on this form is correct and accurate. I am aware that failure to reveal relevant information could result in the early termination of placement.*

Signature

Date

One more thing to do....

Please fill in the applicant's details on the 'Medical Questionnaire' and ask your General Practitioner to complete and return it to us.

Thank you.

Coleg Elidyr promotes equal opportunities for all.
No applicant will be disadvantaged by conditions or environments that cannot be shown to be justified.