# Kent Children’s Disability Register

## CHILD’S DETAILS

**First Names:**

**Surname:**

**Alternative Name:**

**Date of Birth:**

- D D M M Y Y

- Male

- Female

**Ethnic Origin:**

**Address:**

**Postcode:**

**Email:**

**Telephone number:**

## Family household in which child lives:

<table>
<thead>
<tr>
<th>Relation to Child</th>
<th>First Name</th>
<th>Surname</th>
<th>Date of Birth</th>
<th>Are they also disabled?</th>
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## Name given to disability(ies) *(if known)*

**Please put a tick against which of the following applies to the child’s disability:**

### LEARNING

- [ ] Mild

- [ ] Moderate

- [ ] Severe

- [ ] Profound

### PHYSICAL

- [ ] Mild

- [ ] Moderate

- [ ] Severe

- [ ] Profound

### SENSORY

- [ ] Mild

- [ ] Moderate

- [ ] Severe

- [ ] Profound
MOBILITY
Is your child able to:
- Walk
  - Yes
  - No
  - With help
- Go Upstairs
  - Yes
  - No
  - With help
Do you use a Wheelchair / Buggy:
- Yes
- No
- Sometimes

Please list any other specialist equipment:

SELF-HELP SKILLS
Can your child do the following appropriate to age:

Please tick this box if your child is too young to display the following skills:

- WASHING
  - Yes
  - Not at all
  - With help
  - Under supervision
- DRESSING
  - Yes
  - Not at all
  - With help
  - Under supervision
- FEEDING
  - Yes
  - Not at all
  - With help
  - Under supervision

HEALTH NEEDS
Does your child have any complex health needs – i.e., feeding by gastric tube, life limiting illness.
- Yes
- No

BEHAVIOUR
Does your child display any inappropriate behaviour?
- Yes
- No
- Occasionally

e.g., Hitting, self injury, damaging, attention seeking, unacceptable personal habits, etc.) Please comment

Has your child been referred to a Behaviour Management Service?
- Yes
- No

e.g., Behaviour Support Unit, Community Learning Disability Team, etc.)

COMMUNICATION
Is English your child’s first language
- Yes
- No

If no, please state first language:

Does your child have difficulties processing information?
- Yes
- No

Is your child’s speech: (please tick which applies)
- Age Appropriate
- Impaired
- One or two words
- No speech
- Basic Needs

Does your child use or understand a signing system or sign language?
- Yes
- No

If Yes, which type i.e., Makaton, BSL etc.?

Does your child use a communication tool?
- Yes
- No

If Yes, which type?
EDUCATIONAL PLACEMENT CHILD ATTENDS

Name / Address of Nursery / Centre / School your child attends:

Is it ☐ Residential ☐ Day

If placement is Residential, please indicate which is appropriate out of the following:

☐ Weekly ☐ Termly ☘ 48/52 Week Placement ☐ Other

Does your child hold a Statement of Special Educational Needs? ☐ Yes ☐ No

If No, is your child currently undergoing Statutory Assessment of Special Educational Needs? ☐ Yes ☐ No

SUPPORT SERVICES

What Support Services are used and how frequently (i.e., daily, weekly, monthly) e.g., Speech Therapy, Physiotherapy, Link Family Scheme, Music Therapy, Art Therapy, Direct Payments, etc.

Is the amount of support received enough? ☐ Yes ☐ No

What other services do you feel would be useful to you?

FUTURE REQUIREMENTS (within the next 5 years – please tick which you feel would be most appropriate)

☐ Adapted Housing ☐ Supported Housing

☐ Independent Living Scheme ☐ Too young to make a decision currently

☐ Living with Family or Carers ☐ Other (please state below)

SHORT TERM SHARED CARE

Does your child receive shared care? ☐ Yes ☐ No

Name of Provider:

Address:

If overnight, how many anticipated overnight stays per year?
Are you in touch with any **Voluntary Organisations**? e.g., Mencap, Autistic Society, Scope

RECREATION / LEISURE – what activities does your child take part in outside of the family? (Clubs, playschemes, etc.)

Do you have any additional comments you would like recorded?

*(Please feel free to continue on a separate sheet if necessary)*

**SOCIAL WORKER** (if applicable)

Name:
Address:
Telephone number:

**Information given by (please print)**

Name:
Address:
Telephone number:

Relationship to child:

Are you willing for us to forward information from KCC or other relevant organisation to you? (Includes Children’s Disability Register Newsletter)

- [ ] Yes  - [ ] No

Would you be willing for the information contained in this form to be shared with other professionals from Health and Education for planning purposes?

- [ ] Yes  - [ ] No

Signed: (parent / carer) ______________________ Date: __________

Please return this form to:  Children’s Disability Register Co-ordinator
Management Information Unit
Kent County Council
3rd Floor, Invicta House
Maidstone
Kent ME14 1XX
Tel: 01622 694719
www.kent.gov.uk/cdr