**Information & Training Opportunities**

**Expression of Interest Form – Parent / Carer**

**Data Protection**

By completing this form you are consenting to the information being included on KIDS database for the Wakefield District. KIDS will use the details you provide to book you onto workshops and send out information about future events.  We will share some or all of the information you have supplied with Wakefield Council and NHS Wakefield District to plan and coordinate training delivered through these services.

If you have any queries about how we process your data, or wish to see what information we are holding about you, then please write to KIDS WeSail, Office Suite 7, Bizspace Business Park, Denby Dale Road, Wakefield, WF2 7AZ.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Parent / Carer Name** | | | | | | | | | | **Ethnicity** | | | | | | | | |
| **Address** | | | | | | | | | | **Relationship to child** | | | | | | | | |
| **Contact Number** | | **Email** | | | | | | | | | | | | | | | | |
| **Please advise if you have a disability and if so what support you require** | | | | **Dietary needs** (refreshments & lunch may be provided – please refer to information sheet) | | | | | | | | | | | | | | |
| **Name of 2nd attendee** (please check they consent to you sharing this information) | | **Ethnicity** | | | | | | | | | | | | **Relationship to Child** | | | | |
| **2nd attendee’s disability and support required** | | | | **2nd attendee’s dietary needs** | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | | |
| **Please tick which workshops you have *previously* attended** | | | | | | | | | | | | | Attendee 1 | | | | | Attendee 2 |
| Information & Advice Sessions - please state which ones | | | | | | | | | | | | |  | | | | |  |
| Early Support Sleep Workshop | | | | | | | | | | | | |  | | | | |  |
| Balancing Act Workshop | | | | | | | | | | | | |  | | | | |  |
| Stepping Stones Programme | | | | | | | | | | | | |  | | | | |  |
| Early Support Autistic Spectrum Disorder (ASD) Workshop | | | | | | | | | | | | |  | | | | |  |
| Early Spirals Programme | | | | | | | | | | | | |  | | | | |  |
| Spirals Parent Programme | | | | | | | | | | | | |  | | | | |  |
| Cygnets Parent Programme | | | | | | | | | | | | |  | | | | |  |
| Other – please state (including training from other providers e.g. Therapeutic Crisis Intervention - TCI) | | | | | | | | | | | | | | | | | | |
| **1st Child’s Name** | | | | | | | | | **Date of Birth** | | | | | | | **Male / Female** | | |
|  | | | | | | |  | | |
| **1st Child’s Address (if different)** | | | | | | | | | **Ethnicity** | | | | | | | | | |
| **1st Child’s Disability or Additional Needs:** | | | | | | | | | | | | | | | | | | |
| Global Developmental Delay | Learning Disability | | | | | | | | | ADHD | | | | | | | | |
| Cerebral Palsy | Hearing Impairment | | | | | | | | | ASD – awaiting diagnosis | | | | | | | | |
| Downs Syndrome | Visual Impairment | | | | | | | | | ASD – diagnosis received | | | | | | | | |
| Other (please state) | | | | | | | | | | | | | | | | | | |
| **Name of Nursery / School / College** | | | | | Mainstream | | | | | | Specialist Resource | | | | | | Special School | |
| **Does your child receive any of the following support?** | | | | | | | | | | | | | | | | | | |
| **Social Care** | | | **Education** | | | | | | | | | | | | | | | |
| Common Assessment Framework (CAF) | | | My Support Plan (MSP) | | | | | | | | | | | | | | | |
| Early Help Hub | | | Education, Health & Care Plan (EHCP) | | | | | | | | | | | | | | | |
| Social Worker | | | Other (please state) | | | | | | | | | | | | | | | |
| **2nd Child’s Name** | | | | | | | | **Date of Birth** | | | | | | | **Male / Female** | | | |
|  | | | | | | |  | | | |
| **2nd Child’s Address (if different)** | | | | | | | **Ethnicity** | | | | | | | | | | | |
| **2nd Child’s Disability or Additional Needs:** | | | | | | | | | | | | | | | | | | |
| Global Developmental Delay | Learning Disability | | | | | | | | | ADHD | | | | | | | | |
| Cerebral Palsy | Hearing Impairment | | | | | | | | | ASD – awaiting diagnosis | | | | | | | | |
| Downs Syndrome | Visual Impairment | | | | | | | | | ASD – diagnosis received | | | | | | | | |
| Other (please state) | | | | | | | | | | | | | | | | | | |
| **Name of Nursery / School / College** | | | | | | Mainstream | | | | | | Specialist Resource | | | | | Special School | |
| **Does your child receive any of the following support?** | | | | | | | | | | | | | | | | | | |
| **Social Care** | | | **Education** | | | | | | | | | | | | | | | |
| Common Assessment Framework (CAF) | | | My Support Plan (MSP) | | | | | | | | | | | | | | | |
| Early Help Hub | | | Education, Health & Care Plan (EHCP) | | | | | | | | | | | | | | | |
| Social Worker | | | Other (please state) | | | | | | | | | | | | | | | |

**Please complete the attached form to show which workshops you would like to attend.**

**Please refer to enclosed calendar and indicate which dates you wish to attend**

|  |  |  |  |
| --- | --- | --- | --- |
| **Workshops & Sessions** | **Attendee 1** | **Attendee 2** | |
| Information & Advice Session - **Education** |  |  | |
| Information & Advice Session - **Communication** |  |  | |
| Information & Advice Session - **Sensory Processing** |  |  | |
| Information & Advice Session - **Behaviour** |  |  | |
| Information & Advice Session - **Toileting** |  |  | |
| Information & Advice Session - **Feeding** |  |  | |
| Information & Advice Session - **Anxiety** |  |  | |
| **Early Support Sleep Workshop** |  |  | |
| **Balancing Act Workshop** |  |  | |
| **Stepping Stones Programme** |  |  | |
| **Early Support ASD Workshop** |  |  | |
| **Early Spirals Programme** |  |  | |
| **Spirals Parent Programme** |  |  | |
| **Cygnets Parent Programme** |  |  | |
| * Places are allocated on a “first come first served basis” and will be confirmed in writing within 10 working days of receipt of your Expression of Interest form * If you are unsuccessful in gaining a place you will be contacted by phone & offered the next available date or placed on the reserve list | | | |
| **Name** | **Signature** | | **Date** |

**Please return to:**

KIDS WeSail,

Office Suite 7, Bizspace Business Park,

Denby Dale Road,

Wakefield,

WF2 7AZ