**Parent/Carer views and information towards EHC Needs Assessment**

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| **Name of** **Child/Young Person** | **First Name:** | **Family name/surname:** |
| **Date of Birth** |  |
| **Current School/Setting** |  |
| **Date** |  |

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| **Does your child have any existing diagnoses or health needs?****What are the main areas of difficulties your child has? Please tick relevant boxes.** **Physical Health Behavioural Hearing Vision Other** |
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| **Do you have any concerns regarding how your child’s health condition is supported in the school setting? e.g. hearing aids; glasses; wheelchair; access to toilet, etc** |
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| **Is your child under a consultant in the hospital?****If so, please give the consultant’s name and details of hospital/clinic** |
| **Please send any reports you would like the SEND Officer to see when you return this questionnaire to school.** |

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| **Is your child on any medical treatment?** **Does the medication need to be given during school hours? Please give details** |
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| **5.** | **What is important for your child now?** |
| *Things to consider – your child’s favourite lessons; support that is working well; their best part of the day/week and their hobbies and clubs, being independent at home and things they are able to do for themselves.*  |

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| **7.** | **Our hopes and aspirations for our child’s future**  |
| *Your hopes and dreams for your child’s future, including Preparation for Adulthood e.g. employment/education, living a healthy life, where they may live, independent skills and how to be a part of the community through friendships and relationships with others.*  |

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| **Is there anything else you think we should know?** |
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