Club Registration Pack

*All sections must be completed before service can be begin. Once completed please return to* [*info@supportinthecommunity.com*](mailto:info@supportinthecommunity.com)

|  |  |
| --- | --- |
| **Service User.** | |
| Name |  |
| D.O.B |  |

|  |  |
| --- | --- |
| **First Emergency Contact.** | |
| Name |  |
| Relationship |  |
| Address |  |
| Contact |  |

|  |  |
| --- | --- |
| **Second Emergency Contact.** | |
| Name |  |
| Relationship |  |
| Address |  |
| Contact |  |

|  |  |  |
| --- | --- | --- |
| **Service User Key Information** | | |
| List of disabilities, difficulties and other medical information |  | |
| Do’s / Likes | | Don’ts / Dislikes |
|  | |  |

|  |  |
| --- | --- |
| **Approved and trusted person** *(Here provide details of someone you approve to pick up the service user or who we can contact should we not be able to reach the emergency contacts).* | |
| Name |  |
| Relationship |  |
| Contact |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Disabilities, difficulties and diagnosis** *(the services user experiences the following difficulties).* | | **X** | |
| Learning disability/ difficulty | |  | |
| Physical disability/ difficulty | |  | |
| Mental health issue/ difficulty | |  | |
| **Description** *(please explain each of the options you have selected above).* | | | |
|  | | | |
| **Does the service user have an ECHP?** | Yes | | No |
| **If yes can you provide an up to date copy before service commences?** | Yes | | No |
| **Is the service user considered to have challenging behaviours?** *(please describe below).* | Yes | | No |
|  | | | |
| **Is the service user prone to running away?** *(Please describe below any causes/triggers/techniques).* | Yes | | No |
|  | | | |
| **Has the service user ever shown aggressive behaviours or caused harm or injury to someone caring for them?** *(Please describe below causes/triggers/techniques).* | Yes | | No |
|  | | | |
| **Communication** *(please describe the services user’s level of verbal communication, communication techniques or any triggers).* | | | |
|  | | | |
| **Mobility** *(please describe the service users’ level of mobility, any injuries or illnesses we should be aware of etc.)* | | | |
| **Can the service user use stairs unaided?** | **Yes** | **No** | |
|  | | | |
| **Personal support** *(please describe any personal support the service user may require including any support with food or drinks, bathroom or clothing and personal safety).* | | | |
|  | | | |
| **Medication** *(please describe any medication the service user may be on, please include full name and dosage for emergency purposes).* | | | |
|  | | | |
| **Allergies** *(please describe any allergies the service user may have, food or otherwise. Please include preferred treatment method. E.g: some mild allergies may be treated with Piriteze)* | | | |
|  | | | |
| **Questions?** *Feel free to use the space below for any questions you may have, ready to be answered at the Initial Assessment Meeting to discuss what support we can offer.* | | | |
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