**SKY Group Registration Form**

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| **Personal / Contact Information**  | Please complete this section with details about the person accessing the group and with their contact details: |
| **Who is completing this form?** | **Myself** |  | **Parent / Carer** |  | **Professional / GP** |  | **Other**  |  |
| **Full name:** |  |
| **Age:** |  |
| **Address:**  |  |
| **Preferred method of contact :** | **Please write below the main contact details you wish us to use when contacting you about the groups:** |

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| **Important / Medical Information**  | These questions are to determine if we need to make any adjustments in order for you to access our service, or anything we need to be aware of whilst you are with us. Please complete this section as thoroughly as possible. If required, we may need to discuss this section with you or ask you for further information. |
| **Medical Conditions / Other Disabilities**Do you have any medical conditions, other disabilities or serious allergies?  **Y / N** *If ‘Y’ please provide details such as: How can we help / support you with this? What do we need to do if you have an issue with your medical condition or allergy whilst you are here?* *(E.G. If you require medical equipment, asthma inhaler, insulin dispenser etc. please tell us where you keep this and how to help you use it)* |
| **Mental Health Issues**Do you have any mental health issues we need to be aware of?  **Y / N** *If ‘Y’ please provide details such as: Will this affect you accessing our service? Is there anything we can do to support you with this? What are your triggers? What do we need to do if you have an issue with your mental health whilst you are here? (Mental Health issues could include depression, high anxiety, anger issues, OCD, phobias)* |
| **Criminal Record**Do you have a criminal record?  **Y / N** *If ‘Y’ please provide details. Please note any criminal record you have will be discussed with you and any risk is assessed. It will not automatically exclude you from undertaking any support within our service.*  |
| **Triggers** Are there any triggers that can increase the likelihood of you becoming distressed? **Y / N** *If ‘Y’ please provide details of the triggers and of how we can support you should you become distressed during a group.* |
| **Anything else** Is there anything other information you would like us to know? For example, any sensory issues, history of vulnerability or absconding.  |
| **Emergency contacts**  | **Contact 1** | **Contact 2 (if required)** |
| **Name:** |  |  |
| **Relationship to you:** |  |  |
| **Contact details:** |  |  |
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| **Please read before signing:*****The information that I have provided is correct to the best of my knowledge. I understand that this information will be used only for the purposes of me accessing this the SKY groups. I understand that my details will be stored securely and in accordance with the confidentiality and data protection policies of SKY Autism Support.*****Signature:** **Print name:** **Date:**  |