# Early Years

# Individual Support Plan

# –Templates Pack

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## Overview of Pack

Please use this pack alongside the EYISP Guidance Document.

The templates included within this pack can be completed online or printed to be written on. You may use some of the pages a number of times while you are supporting a child. It is important to keep copies of previous documents to give an overview of progress.

### Section 1 – Information for Key Person and SENCO

To be completed by the setting, with information from the child’s family when this pack is being completed. This must be updated with the family before being shared with professionals and/or a new setting.

* Front Page
* Child Details
* Parent/Carer views
* Key Person/SENCO Notes
* Support Overview – Graduated Approach

### Section 2 – Universal Records

To be completed with the family for all children – this information may be saved elsewhere but will be added to this pack when information is shared with other professionals.

* All About Me
* Progress Overview
* Two Year Review

**Section 3 – Individual Planning**

To be completed with the family for all children with SEND

* One Page Profile
* Individual Plan
* Action Plan for Inclusion

**Section 4 – Specialist Planning**

To be completed with the family for some children with SEND if appropriate

* Healthcare Plan
* Risk Management Plan

**Section 5 – Transition Planning**

To be completed for all children with SEND to plan for their transition to a new setting

* Supported Transition Plan

**Section 6 – Evidence Gathering**

To be used when gathering information and sharing the documentation for assessment or transition.

* Checklist
* EHCNA Request Form

**SEN Support Plan for [child’s name]**

***Insert Picture of child***



*Insert Setting Logo here*

|  |
| --- |
| **My plan is supported by -** |

## Child’s details

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name |  | Date of Birth | | Expected school start date |  |
| Address |  | | | Post code |  |
| Ethnicity |  | Religion |  | Home language |  |
| Inclusion Funding awarded? | Yes / No | Funding Band |  | Date Awarded |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Parent / Carer details (with parental responsibility) | | Cared for by the LA |  |
| Name |  | Relationship to the child |  |
| Address (if different from above) |  | Postcode |  |
| Telephone numbers |  | Email address |  |
| Name |  | Relationship to the child |  |
| Address |  | Post code |  |
| Telephone number |  | E-mail address |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Educational setting details | | | |
| Name |  | Address |  |
| Contact person / position |  | Telephone number |  |
|  |  | Email Address |  |

|  |  |
| --- | --- |
| Details of child’s GP | |
| Name |  |
| Address |  |

**Professionals who support me**

**Contact details for involved professionals**

|  |  |  |
| --- | --- | --- |
| **Name** | **Role** | **Contact Details**  **(Email address and/or Telephone Number)** |
|  |  |  |
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|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes/No** | **Date initiated** | **Date completed**  **(or state ‘ongoing’)** |
| Early Help Plan |  |  |  |
| Child in Need |  |  |  |
| Child Protection |  |  |  |
| Personal Education Plan (Cared for Child) |  |  |  |
| Health Care Plan |  |  |  |
| Risk Assessment |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Related plans or assessments** *(add to list as needed)*

|  |
| --- |
| **Summary of Special Educational Needs**  An overview of needs and the diagnoses |
|  |

## Parent/Carer Views

Space to add a photo

of your child

|  |  |  |  |
| --- | --- | --- | --- |
| Child’s name |  | Child’s date of birth |  |
| Your relationship to the child |  | Date form completed |  |

|  |  |
| --- | --- |
| Please tell us about your child’s strengths (what you feel your child is really good at and what makes you proud of them) |  |
| Please tell us about the things your child needs extra help with (if your child has any difficulties that means they require additional support, or if they find some things particularly hard) |  |
| Please tell us about the next steps for your child (this could be any change coming up or a new activity they are about to start) |  |
| Please tell us about your hopes, dreams and aspirations for your child – now, into school and into adulthood. |  |
| Please tells us about any worries or concerns you have about you child – now, into school and into adulthood |  |
| Please tell us anything else that you would like us to know about your child |  |

## Key Person/SENCO notes

Discussion with parent carers, meetings, telephone conversations, review dates, professional visits and conversations

|  |  |  |
| --- | --- | --- |
| Date | What happened? Who did you talk to? What did you find out? | Comment / Actions |
|  | E.g. Discussion with my parents / carers |  |
|  |  |  |
|  |  |  |
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## Support Overview – Graduated Approach

This area is designed to enable you to record a summary of each review phase within the APDR Cycle. These summary boxes will help you evidence with your graduated response/progression in supporting the child over time.

At each stage, you should consider the ongoing support needed by the child, it may be appropriate to: return to universal support, continue to support within setting or to access support from external professionals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Cycle Number | Date Completed | Reviewed by  who | Summary and Next Steps | | |
| Progress Made | Additional Support Provided within the setting | Next Steps and Ongoing Support |
|  |  |  |  |  |  |
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|  |
| --- |
| All About Me |
| **My favourite things at home are:**  (This might include toys, games, comfort objects, stories, places …) |
|  |
| **Meaningful or special relationships in my life are:**  (This might include family members, friends, people who look after me, other people involved in my life, even pets! Photos are lovely to see and share – and it helps us to know who everyone is!) |
|  |
| **My routines are:**  (This might include eating and sleeping routines, the kind of cup I use, my toileting habits, my routines, and who will usually bring and collect me.) |
|  |
| **How I communicate:**  (This might include special words or gestures, home language or any other types of communication I use.) |
|  |
| **My feelings:**  (This might include what makes me happy, sad, angry or scared and how I show these feelings.) |
|  |
| **When I am feeling … it helps me if …** |
|  |
| **Anything else you might need to know about me:**  (This might include any health care needs, other people who are involved in my well-being, or any other information I would like to share with you.) |
|  |
| **Ongoing observations and discussions:** |
|  |

## Individual Progress Review and Planning

**Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Child’s Voice** |
| **Parent/Carers comments** |
| **Key Person comments** |
| **Characteristics of Effective Learning** including how I engage in learning experiences, what motivates me and my thinking skills |
| **Strengths and Interests** |
| **Any Worries** |
| **Parent’s signature Key Person’s signature Date** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Terms** | **Personal, Social and Emotional Development** | **Physical Development** | **Communication and Language** |
| **Term 1 -**  Date:-  **Strengths** |  |  |  |
| **Next steps** |  |  |  |
| **Term 2**  Date:-  **Strengths** |  |  |  |
| **Next Steps** |  |  |  |
| **Term 3**  Date:-  **Strengths** |  |  |  |
| **Next Steps** |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Terms** | **Literacy** | **Mathematics** | **Understanding the World** | **Expressive Arts & Design** |
| **Term 1 -**  Date:-  **Strengths** |  |  |  |  |
| **Next steps** |  |  |  |  |
| **Term 2**  Date:-  **Strengths** |  |  |  |  |
| **Next Steps** |  |  |  |  |
| **Term 3**  Date:-  **Strengths** |  |  |  |  |
| **Next Steps** |  |  |  |  |

## 2 Year Old Progress Check

**Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Characteristics of Effective Learning** including engagement, motivation and thinking | | |
| **Learning and Development summary** | | |
| **Personal, Social and Emotional** | **Communication and Language** | **Physical** |
| **Areas in which I am making progress** | | |
| **Areas where I need more support** | | |
| **Together we will…** (including who is responsible and review date) | | |
| **Parent’s signature Key Person’s signature Date** | | |

[](http://www.google.co.uk/url?sa=i&rct=j&q=&esrc=s&frm=1&source=images&cd=&cad=rja&uact=8&ved=0ahUKEwjDov6v9cjOAhWBPBoKHdVlCEYQjRwIBw&url=http://all-free-download.com/free-vector/download/stick_figure_clip_art_23608.html&psig=AFQjCNG852My5C2P4aRldrKOrPKg3qaCyA&ust=1471539075229045)

## My One Page Profile

**Child’s Name:**

**This is ME**

**MY gifts, strengths and talents**

**DOB:**

Photo of me

**HOW** **to support me…**

**What’s important to ME…**

**Date completed with**

**Child’s Name:**

**Parent/ carer:**

**DOB:**

* **2. What is going well now?**
* **3. Any worries…**
* **5. What can you do to help me? (Next Steps)**

**School start date:**

Photo of ME

* **4. My Outcomes (possible and positives)**
* **6. Review date:**

**Review Notes:**

* **1. My Dreams**

(Gifts, strengths and talents)

## Individual Plan

## Action Plan for Inclusion

This plan should outline what needs to happen within the setting to enable the child to be included, have access to high quality learning experiences and make progress.

|  |  |
| --- | --- |
| Photo of the child (optional) |  |
| Child’s Name: |  |
| Child’s DOB: |  |
| Child’s area(s) of need:  (tick all that apply) | * Communication and Interaction * Social, Emotional and Mental Health * Cognition and Learning * Physical * Sensory * Medical |
| Is the child/family/setting already in receipt of any additional funding?  (tick all that apply) | * Inclusion Funding * EYPP * Deprivation Supplement * DLA – Disability Living Allowance * DAF – Disability Access Fund * Other (please state what type of funding): |
| Setting name: |  |
| Key Person: |  |
| SENCO: |  |
| School start date: |  |
| Meeting Attendees: |  |

|  |  |
| --- | --- |
| What Is Working Well? |  |
| What Are We Still Worried About? |  |
| What Do We Need to Do Next? |  |

Date of Action Plan: Date for Review: By whom:

|  |  |  |  |
| --- | --- | --- | --- |
| Support needed by the child in the setting  Please be specific | Actions for the setting   * Who, what, where when? Please be specific | Review of impact and progress  Please be as detailed as possible. | Next Steps |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

For Inclusion Funding, submit at least **one reviewed Action Plan with Next Steps** and last two individual planning documents. Providers must be able to evidence at least one Assess, Plan, Do, Review cycle.

## Action Plan for Inclusion – Additional Sheet

Date of Action Plan: Date for Review:

By whom: APDR Cycle Number:

|  |  |  |  |
| --- | --- | --- | --- |
| Support needed by the child in the setting  Please be specific | Actions for the setting   * Who, what, where when? Please be specific | Review of impact and progress  Please be as detailed as possible. | Next Steps |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

For Inclusion Funding, submit at least **one reviewed Action Plan with Next Steps** and last two individual planning documents. Providers must be able to evidence at least one Assess, Plan, Do, Review cycle.

## Healthcare Plan

This is to help you to plan to support a child’s health care needs, and is **not** a statutory Education, Health and Care Plan (EHCP).

**Setting**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILD’S

PHOTO

**Child’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of plan:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACT INFORMATION**

**1st Family Contact 2nd Family Contact**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to child: \_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_

**Clinic/hospital contact**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic/hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

G.P. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If medication is required a copy of the prescription or health professional’s letter regarding administration details of any medication should be attached to this form.

**My health or medical needs are…**

**My daily care needs are…**

**It is an emergency if this happens**…

**In an emergency, please do the following …**

**IN AN EMERGENCY PLEASE DO THE FOLLOWING**…

**Who is responsible?**

**My follow-up care needs are…**

**Signed:**

Parent/Carer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Setting:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and signature of child’s healthcare practitioner to verify these details are correct:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PIN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Risk Management Plan

Date of assessment: Setting:

**Child’s Name: DoB:**

**Is there a Healthcare Plan? Yes / No**

**Other Relevant information**

**\_**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Activity Routine** | **Risk -**  including risks to staff/other children | **Potential benefits -** to the child of  this activity | **Views -**  of child, parent, practitioner,  health professionals | **Actions to be taken -**   * to reduce risk * if risk occurs |
|  |  |  |  |  |
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|  |  |  |  |  |
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|  |  |  |  |  |
|  |  |  |  |  |

**Date plan agreed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Plan agreed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Parent/carer) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Setting staff)**

**Review date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Not more than 6 months ahead)**

## Supported Transition Plan

**Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child’s DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Setting (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Receiving Setting/School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Meeting Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Present at meeting**

|  |  |  |
| --- | --- | --- |
| **Name** | **Role** | **Contact Details** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| **One Page Profile –** please **complete before the meeting** and attach to the front of this plan to describe the child’s interests, strengths, gifts and talents, what is important to the child and how you can help the child. | |
| **Areas of development needing support**  (To be completed before the meeting) | **Strategies that are working well**  (To be completed before the meeting) |
|  |  |

|  |  |  |
| --- | --- | --- |
| **What actions need to be taken to support successful transition:**  (To be completed at the meeting) | | |
| **Agreed Actions** | **Who is involved?** | **Timescale** |
|  |  |  |

**Additional Information**

Is the child:

* Supported by an Early Years and Childcare Advisor (EYCA)
* Known to SEND Under 5s
* Known to the Child Development Centre (CDC)
* Undergoing an Education, Health and Care Needs Assessment (EHCNA)
* Known to Early Help
* Known to Social Care

Information to be shared with the new setting:

|  |  |  |
| --- | --- | --- |
| **Records** | **Information to be shared** | **Date for information to be shared** |
| Learning Journal |  |  |
| SEND information |  |  |
| Safeguarding information   * Including log of concerns * Information from CLAWBA * Notes and actions from Early Help Consultations |  |  |
| Medical Needs   * Include current health care plan, risk management plan, and any other relevant documentation |  |  |
| Any other records currently held by the setting |  |  |

Signatures:

|  |  |
| --- | --- |
| Parent/Carer |  |
| Current Setting |  |
| New Setting/School |  |
| Other Professional |  |
| Other Professional |  |
| Other Professional |  |

## Checklist

***Before submitting this paperwork for EHCNA, you must discuss with your EYCA.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Documentation** | **To be included for transitions** | **To be included for EHCNA** | **Last Updated (date)** | **Tick when added to pack** |
| Front Page | Yes – include most up to date version | Yes – include most up to date version |  |  |
| Child Details | Yes – include most up to date version | Yes – include most up to date version |  |  |
| Parent/Carer views | Yes – include most up to date version | Yes – include most up to date version |  |  |
| Key Worker/SENCO Notes | Yes – include most up to date version | Yes – include most up to date version |  |  |
| Support Overview – Graduated Approach | Yes – include most up to date version | Yes – include most up to date version |  |  |
| All About Me | Yes – include most up to date version | Yes – include most up to date version |  |  |
| Progress Overview | Yes – include current and previous copies | Yes – include current and previous copies |  |  |
| Two Year Review | Yes – if applicable | Yes – if applicable |  |  |
| One Page Profile | Yes – include most up to date version | Yes – include most up to date version |  |  |
| Individual Plan | Yes – include current and previous copies | Yes – include current and previous copies |  |  |
| Additional Assessment data | Yes – include current and previous copies | Yes – include current and previous copies |  |  |
| Reports from other professionals | Yes – include current and previous copies | Yes – include current and previous copies |  |  |
| Action Plan for Inclusion | Yes – include all current and previous copies | Yes – include all current and previous copies |  |  |
| Healthcare Plan | Yes – if applicable, include most up to date version | Yes – if applicable, include most up to date version |  |  |
| Risk Management Plan | Yes – if applicable, include most up to date version | Yes – if applicable, include most up to date version |  |  |
| Supported Transition Plan | Yes – complete as part of transition planning |  |  |  |
| Medical Questionnaire |  | Yes – parents to complete before the information is submitted |  |  |
| EHCNA Request Form |  | Yes – complete once all of the information has been updated and gathered into the ISP |  |  |

## Medical Questionnaire for EHCNA Consideration Panel

**Child’s Name:**

**Child’s Date of Birth:**

**Child’s Address:**

Dear Parent/carer,

As you will be aware your school is preparing to ask the Local Authority (LA) to consider undertaking an Education Health and Care Needs Assessment (EHCNA) of your child’s special educational needs.

If the panel decide this assessment should go ahead, the LA *must* seek advice from health as to whether your child has medical needs that will have to be considered in this assessment**.**

Your child may well have seen different professionals in the NHS over the course of their life, however unfortunately not one person or service has access to all this health information. **Therefore, could you please complete the form as soon as possible and return it to your school to add to the request information. This will help to ensure the Panel have the details as part of their consideration.**

Should the needs assessment go ahead, this form will then be sent to your local Child Development Centre to decide if your child requires further medical assessment from a Doctor as part of the EHCNA.

**If the panel decide to start an ECHNA and you are currently open to; a paediatrician/CAMHS/Speech and Language Therapist/physio/occupational therapy, the LA will automatically ask them to contribute to the process. Often this is done based on information they already have about your child but in some cases the professional may need to review your child in order to update this information. Please still complete the 8 questions below as it will provide additional helpful information.**

|  |  |
| --- | --- |
| 1. **Brief** summary of why you/your child’s setting have applied for an EHCNA *(what are your child’s main difficulties/needs)?* |  |
| 1. Does your child have any medical diagnosis? If yes, please can you list these alongside:    1. The dates you received these (if you have these)    2. Who has given the diagnosis (which medical service) |  |
| 1. Was your child born prematurely and/or were there any complications in their first year? If yes to either, please give more details. |  |
| 1. Is your child on any medication currently? If yes, please list medications and dosage. |  |
| 1. Can you list, and briefly detail, any significant health events your child has experienced (eg: surgery, accidents, hospital stays, allergies/anaphylaxis, seizures etc). |  |
| 1. Is your child accessing help from any other health services (other than your GP)? If yes can you list below (examples might include CAMHS, Speech Therapy, Youth Emotional Support Service, Counselling services, Neurologists, dietician etc). ***Please also list private health professionals who may be working with your child.*** |  |
| 1. Has your child been to see your GP, apart from routine immunisations, in the last 6 months? If so, why? |  |
| 1. When was your child’s hearing and vision last checked? Are there concerns in this area? |  |

Thank you for filling this form in. Please now return the form to your child’s setting to submit with the request documentation.

If an EHCNA is started and your local Child Development Centre decide your child would benefit from further medical assessment, they will be in touch to arrange an appointment.

## EHCNA Request Form

**Requestor details:**

|  |  |
| --- | --- |
| Name: |  |
| Role: |  |
| Full name of setting: |  |
| Your email address: |  |
| Your phone number: |  |

**Child’s details:**

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
| DOB: |  |
| Male or female: |  |
| Year group: |  |
| Ethnicity: |  |
| Home language: |  |
| UPN: |  |
| Is child CLA? | Yes No  (If yes details of the Local Authority responsible and social worker including email and phone number must be added here): |

**Parent/Carer Details:**

|  |  |
| --- | --- |
| Name of parent/carer: |  |
| Relationship: |  |
| Do they live at the same address as the child? | Yes No  (If no provide relevant further detail including their address) |
| Email address for parent/carer: |  |
| Phone number for parent/carer: |  |
| Do you need to provide details for a second parent/carer? | Yes No  (If yes provide details here:) |
| Parent hopes/plans for school provision |  |

# Parental Consent

|  |  |  |
| --- | --- | --- |
| **Parent Carer signature:**  **Date:**  I give permission for this plan to be shared with: | | |
| **Name** | **Job Title** | **Contact Information** |
|  |  |  |
|  |  |  |

**Explain to the Education Health and Care Considerations Panel what you are hoping an Education Health and Care Plan could offer the child that is currently not available within your setting’s resources or could not be met by the resources available in setting/school:**

It is helpful when considering your request to understand how you have used your best endeavours to meet a child’s needs.

|  |
| --- |
|  |

**Important information for the professional making this request**:

As the person making this request you are responsible for ensuring the request is made in line with the fundamental principles of the Children and Families Act 2014 (the Act) and the Special Educational Needs and Disability Code of Practice: 0-25 years (January 2015).

Before submitting your paperwork, please make sure you have discussed this with an Early Years and Childcare Advisor (EYCA).

*SEN Code of Practice:*

*1.4 Early Years providers, schools and colleges should also take steps to ensure that young people and parents are actively supported in contributing to needs assessments, developing and reviewing Education, Health and Care (EHC) plans*.

You are required to explain to parents that the information held within this request will be sent to the SEN Assessment Team. You must use your best endeavours to ensure they have seen what has been recorded and that they are aware that the information will be shared with other relevant professionals to enable appropriate support to be put in place to meet the child’s needs.

In line with the Act, it is expected that you will complete this referral with the family adopting the principles of co-production and collaboration.

The SEN Assessment Team will hold and use this information to comply with its legal obligations and in line with their Privacy Notice. You are required to make the family aware of the Privacy Notice information which can be found here on the Local Offer:

<https://westsussex.local-offer.org/information_pages/398-parents-carers-information-privacy-policy>

**Agreement:**

**I confirm that I have explained to the parent/carer that the information within this request will be shared as required to enable appropriate assessment of the child. It will be used to ensure suitable support is in place to meet the child’s needs. I have made the family aware of the SEN Assessment Team Privacy Notice.**

**Signature:**

**Name and role of professional making this request:**

**Date:**