SICKLE CELL & Young Stroke Survivors

YOU are NOT alone
BEFRIENDING SERVICE

# Registration form

## SECTION 1 – Child details

| Parents name: | Parents Surname |
|---|---|
| Parents address:<br><br>Postcode | |
| Email address: | Mobile no: |
| Childs First name: | Childs Surname |
| Childs Address (if different from above)<br><br>Postcode | Date of birth ______/________/_____<br><br>Current age _______________<br><br>Gender<br>Male ☐ Female ☐ |
| Childs mobile no: | Childs email: |

## SECTION 2 – Medical History

| Primary diagnosis | Sickle cell ☐<br>Stroke (Sickle cell Induced) ☐ **Age of 1st Stroke** ________<br>Stroke ☐<br>Moya Moya ☐<br>Blood transfusion ☐<br>Iron Chelation ☐Type ____________________ |
|---|---|
| Other active problems | ADHD/ADD ☐<br>Other behavioural diagnosis ☐<br>Epilepsy/Seizures ☐<br>Other diagnosis ______________________________________<br>Please let us know if your child is Hyperactive |
| **Please comment on above:** Including normal mood patterns e.g. Quite or restless when in pain. Do you use a pain score or chart | |

**Allergies:**

Please state ANY known allergies, including to food/latex etc.:

| Allergy to | What happens | Treatment |
|---|---|---|
| | | |
| | | |

| | | |
|---|---|---|
| | | |

**Emergency Medication and Protocols:**
Please indicate any emergency drugs this young person uses, or alert us to specific protocols that we may find useful for this young person or analgesia in sickle cell or 'sick day' rules.

| Name of treatment or protocol | To be used when |
|---|---|
| | |
| | |
| | |

### Emergency Medical Treatment Details

| Emergency Contact No: | | Email address: |
|---|---|---|
| Doctor's Name: | | |
| Doctor's Telephone Number: | | |
| Doctor's Address: | | |
| Preferred Hospital: | | |

**Immune Status**

Please provide information about immune status for these conditions.

| | Infection (Year, if known) | Immune |
|---|---|---|
| Chicken pox | | Y / N |
| Measles | | Y / N |

Does this young person suffer from cold sores? **YES / NO**
If YES, how frequent are the episodes and how are they treated? ……………………………….
……………………………………………………………………………………………………………

## SECTION 3 – Personal information

Answering the following questions will allow us to assess each young person so that we can meet their needs in the best and safest way possible.

| | | If Yes, please give details: |
|---|---|---|
| **1. Communication** | | |
| Communication difficulties? | Yes ☐ No ☐ | |
| Hearing or visual impairment? | Yes ☐ No ☐ | |
| Behavioural problems? | Yes ☐ No ☐ | |
| Learning difficulties? | Yes ☐ No ☐ | If so, at what age does the child function? |
| **2. Personal care** | | |
| Is help needed with washing and dressing? | Yes ☐ No ☐ | |

| Is help needed when toileting? | Yes ☐ No ☐ | |
|---|---|---|
| **3. Mobility** | | |
| Are there any mobility issues? | Yes ☐ No ☐<br>**If No, go to 4** | |
| Needs wheelchair?<br>How often? | Yes ☐ No ☐ | |
| Climbing stairs? | Unable ☐<br>Able ☐ | **If Yes, please give details:** |
| **4. Eating and drinking** | | |
| Specific dietary requirements?<br>Inc. vegan/vegetarian/coeliac | Yes ☐ No ☐ | |
| Any fluid restrictions? | Yes ☐ No ☐ | |
| **5. Breathing** | | |
| Asthma? | Yes ☐ No ☐ | |
| CPAP or Oxygen required? | Yes ☐ No ☐ | |
| **6. Other medical issues** | | |
| Can they swim? | Yes ☐ No ☐ | |
| Stoma? | Yes ☐ No ☐ | |
| Self-catheterisation? | Yes ☐ No ☐ | |
| Any fits? | Yes ☐ No ☐ | |
| Please mention anything else we should know: | | |

## SECTION 4 – Resuscitation Policy

***In the event of a life threatening episode, is this child for full resuscitation?***

Please tick as appropriate: **YES** ☐ **NO** ☐

**Signed: …..………………………. Print name: ……………………………….. Date: ……………**

***If the answer to this question is NO then we will contact you to discuss this further, so that an individualised plan can be made for any child in this situation.***

**Telephone Number to contact you on ……………………………………………………………………**

## SECTION 5 – Declaration (by person completing form Parent or Carer)

***'To the best of my knowledge, this information is correct at the present time'***

***Please attach evidence of diagnosis and Disability living allowance if in receipt.**

| **Title & Name:** | |
|---|---|
| **Relationship to child:** | |
| **Address:**<br><br>**Postcode** | |
| **Contact telephone number:** | **E-mail address:** |

| Young person's Consultant: | |
|---|---|
| Hospital/Treatment centre: | |

Please give details of who should be contacted for medical advice should this young person become unwell during the activities.

| Name of person or team | Position | Contact Details |
|---|---|---|
| | | |

**Support requirements**: (please give a brief outline of the support you think this young person would need to access our service). Please also include information relating to whether this young person would require assistance with personal matters

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Any other relevant information:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## Parental Consent

I ________________________________________Parent/ Guardian of _______________________ consent to him/her (Please delete as appropriate) taking up a place at SCYSS Youth Club according to the terms and conditions set out in its policies and procedures. I have understood the expectations and obligations relating to both the Club, and myself and my Youth and agree to abide by them.

I understand that persistent lateness, bad behaviour will jeopardise my Youth's continued attendance at the Club.

I confirm that the information given above is correct, and I promise to contact the Club Manager as soon as any of the details change.

I agree for information to be kept on the Sickle Cell & Young Stroke Survivors Database for monitoring purposes. Information will not be passed to outside organisation or individuals, although it will be kept by Sickle Cell & Young Stroke Survivors in accordance with the Data Protection Act 1998.

**I consent to my Youth receiving urgent medical attention if contact with me cannot be made.**
**YES ☐ NO ☐**

I consent to my Youth being photographed whilst taking part in activities, which may be used for future publicity by Sickle Cell & Young Stroke Survivors.

**YES ☐ NO ☐** (please note that photos maybe passed onto funders for proof of funded activities)
If you have any questions or comments please get in touch with the Youth Coordinator.
**I have read and understood the SCYSS Youth Club Rules.**

**I consent** to the above named member being able to take part in activities arranged by the SCYSS Club and confirm that I am responsible for my child's safety whilst travelling to and from the Youth Club and I will ensure that my child abides by them.
All information given is correct to the best of my knowledge. **YES ☐ NO ☐**
**Parents/Carers name:** ____________________________________________________________

_______________________________________ Signature Date:_________/_________/20_______