**Participant Information**

**Parents Form**

ELITE is funded by the European Social Fund to work in a person centred way with young people aged 14 - 19, and their family/carers to identify skills, aptitudes and aspirations regarding future vocational training and employment. We will provide opportunities for participants to take part in work awareness courses and travel awareness courses, and allow them to access work experience placements, voluntary work and paid work opportunities.

As part of your dependents referral to the Real Opportunities Project, it has been established that he/she is interested in learning more about employment and accessing opportunities linked with employment. Following on from the home visit you have had with a project team member, there is some extra information we require to allow us to provide your dependent with an individually tailored program of support to allow them to achieve the most out of the ELITE section of the project.

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| **DATA PROTECTION ACT 1998** |
| Elite may put the information you give onto a computer to assist with job finding. |
| **STATEMENT OF CONFIDENTIALITY** |
| The information contained in this form will remain confidential within elite supported employment agency ltd. |
| **FOR OFFICIAL USE ONLY** |
| **DATE RECEIVED:** |  | **REF. NO.:** |  |
| **PROJECT:** |  |

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| **PARTICIPANT DETAILS** (To be filled in prior to attending initial parent meeting) |
| **Title** |  |
| **First Name(S)** |  |
| **Surname** |  |
| **Address** |  |
| **Post Code** |  |
| **Home Telephone Number** |  |
| **Mobile Telephone Number** |  |
| **E-Mail Address** |  |
| **Please Circle Your Preferred Method Of Contact:** | Post | Home Phone | Mobile Phone | E-Mail |
| **Date Of Birth** |  |
| **National Insurance Number** |  |
| **School** |  |
| **Source Of Referral** |  |
| **Referral Name**  |  |
| **Referral Area** |  |
| **Referral Contact Number** |  |
| **Please Confirm The Correct Spelling Of Your Dependents Name For Use On Their Certificate** |
|  |
| **Your Commitment To The Course And To Work** |
| Planning, organising and delivering any accredited course which involves visits, placements, travel training or any other form of activity takes time, effort and hard work. It is important that, to get the most out of these courses, your dependent must be willing to commit to attend every teaching day and every activity that is arranged. This also applies to paid/voluntary work, if your dependent decides to pursue this after the course.  |
| Are You Prepared To Support You Dependent To Complete The Course/Placement/Job? | **YES/NO** |
| **Emergency Contact** Please Provide Contact Details For Use In Case Of An Emergency |
| **Name** |  |
| **Relationship** |  |
| **Address** |  |
| **Postcode** |  |
| **Home Telephone** |  |
| **Mobile Phone No** |  |
| **Benefits Information** |
| If you think your dependent will be interested in accessing paid employment now or in the future, it would help us if we could obtain some information about the benefits they are receiving. |
|  |
| **Are They/Will They Be Interested In Accessing Paid Employment Opportunities?**Please List Below The Name And Level Of The Benefit Being Received | **YES/NO** |
| DLA Care (Low Med High)  | Amount £ | DLA Mobility (Low / High)  | Amount £ |
| ESA  | Amount £ | JSA  | Amount £ |
| OTHER (PLEASE STATE AMOUNT) |  |
| **Placement Planning Information**To allow us to arrange the most suitable work experience for your dependent please answer the following questions: |
| **What Do You Consider To Be Your Dependents Disability/Difficulty And How Does It Affect Them?**(Include any illnesses/disabilities that affect your dependent) |
|  |
| **Does Your Dependent Travel Independently?** | **YES/NO** |
| **Does Your Dependent Have A Bus Pass?** | **YES/NO** |
| **If Yes, Is It A Companion Bus Pass?** | **YES/NO** |
| **Epilepsy Profile**If Your Dependent Suffers With Epilepsy, Please Fill In The Attached Epilepsy Profile |
| **What Support Would Your Dependent Require From Us To Assist Them In Coping With/Managing Their Illness/Disability?** |
|  |
| **Does Your Dependent Use Any Aids Or Items Of Equipment To Assist Them?** |  | **YES/NO** |
| If Yes, Please Provide Details Below: |
|  |
| **Does Your Dependent Have Any Regular Medical Appointments More Frequently Than Monthly?** | **YES/NO** |
| If Yes, How Frequently? |  |
| **When Assessing Suitable Work Sites For Your Dependent, Are There Any Factors We Need To Consider?** E.g. access, phobias, anxieties, lifts/stairs, asthma etc | **YES/NO** |
| If Yes, Please Provide Details Below: |
|  |
| **Does The Vulnerability Of Your Dependent Require Them To Have The Same Sex Trainer?** | **YES/NO** |
| **If No, Please Confirm That This Person Can Work With Trainers Of Either Gender** | **YES/NO** |
| **Has Your Dependent Ever Been Accused Or Convicted Of A Criminal Offence?** | **YES/NO** |
| **If Yes, Are You Prepared To Disclose What And When?** | **YES/NO** |
| **If Yes, Please Specify:** |  |
| **If Yes, What Was The Resulting Action?** |
| PROSECUTION | COUNSELLING | REFERRED TO Y.O.T. | OTHER |
| DETAILS: |  |
| **Please Include Any Other Relevant Information You Feel May Be Of Importance:** |
|  |
| **Please Sign Below To Confirm That All The Information In The Form Is Accurate At The Time Of Completion** |
| **Signed:** |  |
| **Relationship With Participant:** |  |
| **Date:** |  |
| **For Office Use Only** |
| **Have All Sections Of The Top Up Information Form Been Checked** | **YES/NO** |
| ETC NAME: |  |
| ETC SIGNATURE: |  |
| DATE: |  |