ENROLMENT FOR DAY BASED OPPORTUNITIES AND ACTIVITIES	
FULL NAME:	DATE OF BIRTH:
ADDRESS:	
Email:	
EMERGENCY TELEPHONE NUMBER:	
NEXT OF KIN or: CARER'S NAME:	
Health Issues? eg. Asthma/Epilepsy? Continue overleaf if need be.	Allergies:
CURRENT MEDICATION: Continue overleaf if need be.	RESCUE MEDS: e.g. inhalers/epi pen.
ANY SPECIAL REQUIREMENTS: Eg. Needs easy access, Quiet space, Comes with a support worker etc.	

OTHER HELPFUL INFORMATION: E.g. likes/dislikes/ any behaviour issues? Continue overleaf if need be.	All information given here is for the sole use of TH and will not be passed on to any other parties except in the case of safeguarding. This information will be stored according to the data protection act of 1998 and its amendment of 2018.

I agree for this information to be held by Turning Heads for contact purposes.

Name: Signed: Date:

Or

Parent/ Carer : Print name here:

On behalf of:

Signed: Date:

Permissions

I give consent for _____ to appear on social media posts and give permission for these images to be used for marketing purposes for Turning Heads.

I do not give consent for _____ to appear on social media posts and give permission for these images to be used for marketing purposes for Turning Heads.

PLEASE DELETE THE ONE WHICH DOES NOT APPLY

Any other information: