**CYP Parent/ Legal Guardian Referral and Consent Form**

**Please return by email: wales@cruse.org.uk** All enquiries: 02920 226166

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| --- | --- | --- | --- | --- | --- | --- |
| **(office use only) Received Date:** | | **Referral number:** | | | | **S&U:** |
|  | |  | | | |  |
| **All referrals require consent and all relevant sections must be completed.** | | | | | | |
| **\* Mark the boxes next to the statements below if you give your consent** | | | | | **Consent** | |
| **We need to record yours and your child/young person’s details which we will hold to enable us to deliver a service to your child/ young person. Are you happy to give your consent for us to deliver support to your child/ young person via Zoom and/or in-person? (**please delete as appropriate) | | | | | Zoom  In-person  Group | |
|  | | | | | | |
| **With your consent we will also use your details to contact you about Cruse services, activities and ways you can support Cruse. Are you happy to give your consent?**(You have the right at any time in the future to withdraw your consent. We confirm that your information will not be sold to any third parties.) | | | | | Yes / No | |
| **Consent for Child/Young Person:** | | | | | | |
| Name and Address of Parent/ Legal Guardian |  | | | | | |
| Contact Telephone number of Parent/ Legal Guardian |  | | | | | |
| Email Address of Parent/ Legal Guardian |  | | | | | |
| I confirm that I have legal parental/guardian responsibility for the referred child/young person and consent to them receiving support. | | | | | | |
| Signed: |  | | Date: |  | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **About Child/Young Person** | | | | | | | | | |
| Full Name |  | | | | | | | | |
| Email Address |  | | | | | | | | |
| Main Contact Number(s) | 1 |  | | | | 2 | |  | |
| Best time to call |  | | | | | | | | |
| Can we leave a voicemail? |  | | | | | | | | |
| Home Address |  | | | | | | | | |
| County and Postcode |  | | | | | | | | |
| Language Preference |  | | | | | | | | |
| Date of birth |  | | | | | | | | |
| School |  | | | | | | | | |
| School Telephone Number |  | | | | | | | | |
| **Equal Opportunity Questions** | | | | | | | | | |
| Gender |  | | | | | | | | |
| Do you consider your child/ young person to have a disability? | Yes | |  | No |  | | Prefer not to say | |  |
| Details of disability |  | | | | | | | | |
| **Medical Support & Conditions** | | | | | | | | | |
| Details of any medication/conditions |  | | | | | | | | |
| Name of GP |  | | | | | | | | |
| GP Surgery Address |  | | | | | | | | |
| GP Telephone Number |  | | | | | | | | |
| **Details of your bereavement** | | | | | | | | | |
| Name of deceased |  | | | | | | | | |
| Cause of death |  | | | | | | | | |
| Relationship to your child/ young person |  | | | | | | | | |
| How old were they |  | | | | | | | | |
| Date of bereavement |  | | | | | | | | |
| Place of bereavement |  | | | | | | | | |
| Details of Bereavement  Please tell us about your child/ young person’s bereavement, what happened, how you feel it is effecting them, and any worries or concerns you or they may have. |  | | | | | | | | |
| 1. How often do these issues affect your child/ young person? |  | | | | | | | | |

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