St. Christopher's Special School

Battery Road, Longford. Telephone 043 3341073 Email:office@stchrisschool.ie

APPLICATION FORM.

Private and confidential without prejudice.

PUPIL DETAILS;

1. Name: _____
2. Address: _____

   _____

   _____

   Eircode: _____
3. Email address: _____
3. Date of Birth: _____
5. P.P.S. Number: _____
6. Home Telephone No: _____
7. Language spoken at home: _____
8. Religion: _____
9. Country of Birth: _____
10. Nationality: _____

FAMILY:

(a) Name of Parents or Guardian;

Mother : _____

Address: _____

_____

Home Number:_____

Mobile Number:_____

Work Number:_____

Occupation:_____

Email:_____

Father: _____

Address: _____

_____

Home Number:_____

Mobile Number:_____

Work Number:_____

Occupation:_____

Email:_____

It is school policy to pass on the above information to the Department of Education

Emergency Contact details/ Alternative Number if parent/guardian not available.

Name : _____ No: _____ Relationship to child:_____

Name : _____ No: _____ Relationship to child:_____

Text a Parent system: School can communicate with you by text.

Contact Name for Text a Parent _____

Telephone Number for Text a Parent _____

(d) Siblings;

Name:	Date of Birth:	Present School
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

MEDICAL:

1. Family Doctor's Name: _____
   Address: _____
   _____
   Telephone No: _____
2. Medical Card No: _____

3. Has your child been psychologically assessed? YES ☐ NO ☐
   If so, when _____
   By Whom? _____

4. Is your child on regular medication? YES ☐ NO ☐
(if so please give details)

_____
_____
_____
_____

5. Does your child have epilepsy? YES ☐ NO ☐

6. Has your child suffered any serious illness? YES ☐ NO ☐

(if so please give details)

_____
_____
_____
_____

GENERAL;

Home Please tick

Is your home situated in a remote area? YES ☐ NO ☐

Are there other children living nearby? YES ☐ NO ☐

SOCIAL/ SELF-CARE;

Does your child make independent use of a toilet?	YES ☐	NO ☐
by day?	YES ☐	NO ☐
by night?	YES ☐	NO ☐
dress and undress independently?	YES ☐	NO ☐
brush own teeth?	YES ☐	NO ☐
wash hands and face?	YES ☐	NO ☐
dry self with towel?	YES ☐	NO ☐
Does you child have any apprehension of danger (i.e. around the fire, in traffic etc.)?	YES ☐	NO ☐
Does your child play socially with other children?	YES ☐	NO ☐
Does your child take turns in games?	YES ☐	NO ☐
Does your child share?	YES ☐	NO ☐
Has your child been evaluated by the Speech Therapist	YES ☐	NO ☐
Does your child require speech therapy?	YES ☐	NO ☐

Why do you want your child to attend St. Christopher's School? _____

_____

_____

Has your child attended any other educational establishments? YES ☐ NO ☐

If so, name them; _____

_____

_____

Is there any other information that you feel we need to know? _____

_____

_____

CONSENT;

1. I give permission for my son/daughter to be involved in the following activities;

(a) Physical Education	YES ☐	NO ☐
(b) Swimming	YES ☐	NO ☐
(c) Social Outings (in the care of a Teacher or in the care of a Special Needs Assistant)	YES ☐	NO ☐
(d) Aromatherapy	YES ☐	NO ☐
(e) Chiropody	YES ☐	NO ☐
(f) Hydrotherapy	YES ☐	NO ☐
(g) Irish Therapy Dog Visits	YES ☐	NO ☐

If your Son/Daughter is on any medication or has a medical problem please get a letter from your Doctor to state that he/she may avail of the above activities.

2. The Health Service Executive provides services to our pupils. Do you give permission for your child's information to be forwarded to the HSE? YES ☐ NO ☐

I give permission for my son/daughter to receive the following additional services from the HSE if necessary and as required;

(a) Physiotherapy YES ☐ NO ☐
(b) Speech & Language Therapy YES ☐ NO ☐
(c) Occupational Therapy YES ☐ NO ☐
(d) Psychological Assessment YES ☐ NO ☐

EMERGENCY;

I give permission for the staff of St. Christopher's School to implement the following in a medical emergency involving my son/daughter:-

(a) Emergency medical care in the case of minor accidents.
(b) Emergency medical care by a doctor.
(c) Emergency medical care and diagnostic service at a Casualty Department.
(d) Emergency hospital admission and consent for the administration of a General Anaesthetic.

The school may share Personal Pupil data with other organisations such as HSE, Tusla, An Garda Siochána, etc, where there is a legal basis for doing so under GDPR.

Please attach a Birth Certificate and Psychological report (less than one year old) for your child.

Thank you for completing the above form. All information will be safeguarded and is in STRICT CONFIDENCE.

Signature of Parent/Guardian: (Mother) _____
(Father) _____
(Date) _____

ST. CHRISTOPHER'S SPECIAL SCHOOL

MEDICAL EXAMINATION FORM
(To be filled in by family doctor)

NAME OF PUPIL: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

HEIGHT: _____ WEIGHT: _____

MEDICAL CARD NO: _____

1. (A) **SUSPECTED CAUSE OF INTELLECTUAL DISABILTITY**

_____

Any associated conditions that are known to arise as a result of the condition (s) outlined above:

_____

If Down Syndrome: Atlanto axial x-ray required? Yes No

(B) OTHER DIAGNOSIS/SYNDROMES (e.g. cerebral palsy, epilepsy):

_____

2. EYES: Note any abnormality observed:

Right Eye: _____ Left Eye: _____

Has this person been referred for ophthalmic assessment? Yes No

Date of referral: _____ Name of consultant: _____

Prescribed spectacles: Yes No

3. EARS: Note any abnormality observed:

Right Ear: _____ Left Ear: _____

Has this person been referred for a hearing assessment? Yes No

Date of referral: _____ Name of consultant: _____

Prescribed Hearing Aid: Yes No

4. CONDITION OF TEETH AND MOUTH:

Name of Dentist: _____

5. CARDIOVASCULAR SYSTEM:

Pulse Rate: _____ B.P. _____

Has this person any heart defect? _____

6. RESPIRATORY SYSTEM:

Any history of respiratory problems e.g. Asthma, T.B. : _____

Chest X-ray Result (if relevant): _____ Date: _____

7. ALIMENTARY SYSTEM:

Does this person have bowel problems? Yes No

If yes: Constipation _____ Diarrhea _____ Seeping _____ Other _____

Does this person have eating problems? Yes No

If yes: Vomiting _____ Regurgitation _____ Other _____

Special Dietary requirements:

_____

_____

_____

8. GENITO-URINARY SYSTEM including menstrual details:

Any abnormalities: _____

_____

9. CENTRAL NERVOUS SYSTEM:

Muscle Tone:

Epilepsy: Type: _____ Frequency: _____

Date of last medication review and blood levels: _____

Any emergency medication prescribed: _____

10. SKELETAL SYSTEM: (including posture and mobility)

_____

_____

Does this person have or require a physiotherapy service? Yes No

11. ALLERGIES: (include food allergies) Yes No

Please give details:

_____

Has this person been allergy tested? Yes No

12. MEDICATION:

Is this person allergic to any medication? Yes No

If yes, state medication: _____

_____

Is this person presently on medication? Yes No

If yes, give details: _____

NAME OF MEDICATION	DOSAGE	ROUTE	FREQUENCY	ANY SIDE EFFECTS

13. INFECTIOUS DISEASES:
Has your child had any of the following? Please insert dates: _____

Chicken Pox _____ Measles _____ Pertussis _____ Mumps _____

Rubella _____ T.B. _____ Hepatitis _____

Other _____

14. IMMUNISATIONS:

Age	**Immunisations**	**Comment**	**Dates Given**
Birth	BCG	1 injection	
2 months	DTap/Hib/IPV/Hep B + PCV	2 injections	
4 months	DTap/Hib/IPV/Hep B + MenC	2 injections	
6 months	DTap/Hib/IPV/Hep B + PVC + MenC	3 injections	
12 months	MMR + PVC	2 injections	
13 months	MenC + Hib	2 injections	
4 to 5 years	DTap/IPV + MMR	2 injections	
11 to 14 years	Tdap +BCG2	1 injection	

NAME AND ADDRESS OF G.P. Doctor's Stamp

_____

_____

_____

HAS THIS PERSON EVER BEEN IN HOSPITAL: Yes No

If yes, please give details:

IS THIS PERSON UNDER THE CARE OF A SPECIALIST:

ANY RELEVANT INFORMATION YOU MIGHT LIKE TO ADD:

Signed: _____ Date: _____