 Disability Discrimination Act (DDA) Form

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| Student’s First Name: ……………………………………………………………………………………………………………… |
| Student’s Surname / Family Name: …………………………………………………………………………………………. |
| Date of Birth (dd/mm/yy) ……… /........ /……..  |

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| **1. Please indicate whether your child has any long-standing illnesses, health problems or disabilities which mean that they have substantial difficulties with any of the areas of their life shown below? Please select all that apply.***By long-standing we mean anything that has troubled your child over a period of at least 12 months or that is likely to affect them over at least 12 months. Please exclude difficulties that you would expect for a child of that age.* |
| Mobility – moving around indoors or outdoors | [ ]  |
| Hand movements – touching or holding | [ ]  |
| Personal care – going to the toilet, dressing | [ ]  |
| Eating and drinking without help | [ ]  |
| Incontinence – wetting or dirtying  | [ ]  |
| Taking medication | [ ]  |
| Communication - speaking with others, or understanding them | [ ]  |
| Learning – numbers, letters, words | [ ]  |
| Hearing | [ ]  |
| Vision | [ ]  |
| Behaviour – very active, has a short attention span, behaves unacceptably | [ ]  |
| Has fits or seizures | [ ]  |
| Diagnosed with autism or Asperger Syndrome |  [ ]  |
| Has a life-limiting condition or requires palliative care  |  [ ]  |
| Can be depressed, or anxious, or has an eating disorder |  [ ]  |
| Other (please describe other areas of great difficulty) |  [ ]  |

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| **2. Does your child take any medication, use any physical aids or require any special diet or supplements?** | Yes [ ]  | No [ ]  |

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| **3. If your child did not take this medication, use this physical aid or have a special diet or supplements, would they have substantial difficulties with any of the areas of life listed above?** | Yes [ ]  | No [ ]  |

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| **4. Has your child seen a professional, such as a paediatrician or a psychologist or a speech and language therapist because of the difficulty?** | Yes [ ]  | No [ ]  |
| If YES, please provide further details: |

| **5. If you have indicated above that your child has difficulties, do these difficulties affect them:**  | Yes | Sometimes | No | Don’t know |
| --- | --- | --- | --- | --- |
| Classroom learning? | [ ]  | [ ]  | [ ]  | [ ]  |
| Interaction with classmates / peers? | [ ]  | [ ]  | [ ]  | [ ]  |
| Joining in other school activities e.g. breaks, social and leisure activities? | [ ]  | [ ]  | [ ]  | [ ]  |
| Attendance at school | [ ]  | [ ]  | [ ]  | [ ]  |
| Day to day life outside of school  | [ ]  | [ ]  | [ ]  | [ ]  |

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| **6. What sort of help or special equipment do you think your child needs so that they get on well at school?**  |

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| **We would be pleased to meet with you to talk about your child’s need. Please tick if you would like us to arrange this.** | **[ ]**  |

**What Happens** To The **Information You Give Us?**

We really appreciate your help with this questionnaire. The information will be used by the school to improve the way that information on students’ difficulties and disabilities is collected and used in schools to promote the wellbeing of children. No information will be public that would identify your child. By returning this form you are agreeing that information can be used in this way.The attached envelope shows the person in the school who will open the envelope and see this information. Information will be shared with those staff in the school who support your child unless you ask us not to below.

Is there any person in the school who you **would not** like to share this information with?

Please name them: …………………………...........................................…………………………………….

**Please note** - In the case of short term illnesses parents are encouraged to come into school to administer any prescribed medication. In the rare event that medication is brought into school it is essential that this is agreed beforehand with the school. In no circumstances will medicines be accepted which are sent in unmarked containers.

Students using inhalers and Epipens should carry these with them. Please liaise with Pastoral staff. No other medication should be carried around school by students.

**Parents’ signature:** ………………………………………………………….……………..……………………………..  **Date:** ………………………..………….