**My Story – Parent/Carer Guidance**

1. This My Story document will be used to capture your views to support the request for an Education Health Care Plan (EHCP).
2. If more than one parent has shared their views, please ensure that you both sign.
3. My Story will not automatically guarantee an EHCP for the young person. If the request does not progress to an EHCP, My Story can be used to explore services or resources that may be able to support the young person as part of the Salford Local Offer.

**Photograph**

**Optional**

(Parent’s consent required)

**My Story – Parent/Carer**

**POST 16**

**Young Person’s Name;**

**Date of Birth;**

**Address;**

**School/College;**

**Background and Family Make Up**

|  |
| --- |
| **Background** (e.g. premature birth, medical history, past factors that have led to the young person needing additional support) |
| **Who lives in your family?** |

|  |
| --- |
| **Details of previous educational provisions** |

**What do you think your young person’s main difficulties are and what do you think causes these difficulties?**

|  |
| --- |
| **How can we support your young person in college? What works well? What doesn’t work well?** |

**What type of provision would you like/ for your young person (Please tick)**

* Mainstream FE College
* Specialist FE College
* Supported Internship
* Apprenticeship /traineeship
* Other (Please specify)

|  |
| --- |
| **Why do you want this type of provision for your young person?** |

**Future Achievements**

|  |
| --- |
| **What aspirations do I / we have for my/our young person?**  **What wishes do I/we have around my/our young person’s physical/emotional health?**  **What I/we wish for to enable support for my/our young person to become more independent in future?**  **What is important to keep my/our young person safe? (** think of situations where the young person might be vulnerable, such as being around strangers and road safety awareness) |

**Professionals who support the young person**

**From the following list of professionals whose views would you liked to be considered in the assessment?**

|  |  |
| --- | --- |
| **Professional** | **Name and contact details** |
| GP |  |
| Social Worker |  |
| Paediatrician |  |
| Audiologist |  |
| Educational Psychologist |  |
| Speech and Language Therapist |  |
| Advisory team for Sensory Impairment |  |
| Family Support |  |
| Clinical Psychiatrist |  |
| Lead Professional |  |
| Other Specialist (please state) |  |

|  |
| --- |
|  |
| **Further details (Please circle)**   |  |  | | --- | --- | | Does the young person have a CAF (Common Assessment Framework) | Yes / No | | Has the young person had a Special Educational Need Statement / LDA previously? | Yes / No | | Does the young person have a Medical Care Plan or need one to be developed? | Yes / No | | Does the young person have or use any specialist equipment or resources? (e.g. hearing aid, wheel chair) | Yes / No | | Does the young person have a diagnosis? (Please state) | Yes / No | | Has the young person had time in hospital? | Yes / No | | Is the young person on medication? | Yes / No | |

**Personal Information (Young Person)**

|  |  |
| --- | --- |
| Full Name |  |
| Date of Birth |  |
| Address |  |
| Phone Number |  |
| Mobile Number |  |
| Email Address |  |
| Religion |  |
| Ethnicity |  |
| First Language |  |

**Personal Information (Parent)**

|  |  |
| --- | --- |
| Full Name |  |
| Date of Birth |  |
| Address |  |
| Phone Number |  |
| Mobile Number |  |
| Email Address |  |
| Religion |  |
| Ethnicity |  |
| First Language |  |

**Consent for Information Sharing**

**Please sign below to indicate that you understand and give consent to the release and sharing of information as indicated with other local authority partners, health professionals and your young person.**

I (insert name of /parent/carer……………………….................…) give my consent to the above:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Signed** | **Print Name** | **Date** |
| The parent/carer/s understands the information recorded in the My Story |  |  |  |
| Form completed by: |  |  |  |

Please note that should the assessment go ahead the young person will be invited to a local clinic so that their health and progress can be reviewed by a medical professional and advice provided. It is essential that they attend the medical appointment to avoid delays in completing the assessment.