Spiral Sussex
Equal Opportunities for People with Learning Difficulties / Disabilities

MEMBERSHIP FORM

PERSONAL INFORMATION

Title : **Mr / Mrs / Miss / Ms / Mx / Ind / M / Mre / Msr / Myr / Pr / Sai / Misc /** _____

Full Name (CAPITALS) :

Date Of Birth : _____ / _____ / _____

Sex assigned at birth : ☐ Male ☐ Female ☐ Prefer not to say

Gender : **Man / Woman / Transwoman / Transman / non-binary / genderqueer / agender / gender fluid don't know / prefer not to say / other** _____

Religion : _____ **prefer not to say**

Address : _____

Town / City : _____ **Postcode** : _____

Phone Number : _____ **E-Mail** : _____

Mobile Number : _____

CARER / PARENT / GUARDIAN DETAILS

Name of Organisation (if applicable) : _____

Title : **Mr / Mrs / Miss / Ms / Mx / Ind / M / Mre / Msr / Myr / Pr / Sai / Misc /** _____

Full Name (CAPITALS) :

Address : _____

Town / City : _____ **Postcode** : _____

Phone Number : _____ **E-Mail** : _____

Mobile Number : _____

Emergency Contact 1 Name : _____ **Telephone** : _____

Emergency Contact 2 Name : _____ **Telephone** : _____

SUPPORT DETAILS SUMMARY

Medical Diagnoses : _____

Behavioral Issues : _____

Special Dietary Needs : _____

Allergies : _____

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MEDICAL FORM

DOCTOR DETAILS

Name of Surgery (If Applicable) :

Name of G.P.(Doctor) :

Address :

Town / City : **Postcode** :

Emergency Contact : **Mobile** :

1. Do you have a visual impairment or hearing impairment? **YES / NO**

If yes please give details of any help you need to manage these.

2. Do you have any mobility problems **YES / NO**

If yes please give details of any help you need to manage these.

3. Downs Syndrome: **YES / NO**

If yes please give details of your most recent atlanto-axial instability X-ray evaluation (if any).

(Tick One) Positive ☐ **Negative** ☐ **No X-ray** ☐

4. Epilepsy: **YES / NO**

Type of seizures:

How often do you have an Epileptic seizure e.g. weekly,

Do you normally need to take rectal or buccal medication to stop a Seizure ? **YES / NO**

Additional information:

5. Diabetes: **YES / NO**

Type :

How often do you have a hypo (low blood sugar) attack, e.g. weekly

Do you normally need injected medication e.g. Glucagon to stop hypo **YES / NO**

Additional information:

6. Asthma:

Do you suffer from Asthma? **YES / NO**

How often do you have a severe asthma attack?

Do you normally need nebulised medication or oral steroid tablets to stop a severe attack? **YES / NO**

Have you been hospitalized with a severe attack in the last year? **YES / NO**

Additional information: _____

7. Congenital Heart Condition:

Do you suffer from a heart condition? **YES / NO**

Do you attend a hospital cardiology Clinic for regular review? **YES / NO**

Are there any special precautions we need to be aware of for you? **YES / NO**

If YES Please give details:

_____

8. Other Details:

Do you have any other medical conditions or injuries or allergies? **YES / NO**

If YES Please give details:

_____

9. Treatment:

Have you had any treatment by your doctor or hospital within the last 2 years that we should be aware of? **YES / NO**

If YES Please give details:

_____

10. Dietary Information:

Dietary Information and Requirements:

Do you have any food allergies? **YES / NO**

If YES Please give details of the Foods and of the reactions:

_____

Are there need for feeding aids? **YES / NO**

If YES Please give details:

_____

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MEDICAL FORM

Please Confirm when you had your Covid 19 Vaccinations:

Date 1: _____ Date 2: _____ Date Booster: _____

Type of vaccination: _____

Medical Consent Form - To be completed by the Participant and Carer/Guardian

I understand that during Spiral activities or holidays that if I am taken ill or injured to the extent that some medication or surgery is required, and if in the opinion of competent medical authorities, the delay would endanger my life or health, I authorise the leader or duty Medical Officer to sign on my behalf any form of Consent which may be necessary.

I Agree YES / NO

Signed: _____ _____ Date: _____

Carer/Guardian _____ Printed Name: _____ Relationship: _____

11. Is there any history of aggressive or abusive behaviour to others? **YES / NO**

If YES Please give details:

_____

12. Does the participant self harm? **YES / NO**

If YES Please give details:

_____

13. Is there any history of socially inappropriate behaviour? **YES / NO**

If YES Please give details:

_____

14. Do you have any history of walking off from a group or carer or guardian? **YES / NO**

If YES Please give details:

_____

15. Does the participant have any walking difficulties? **YES / NO**

If YES Please give details:

_____

16. Are there any support needs for toileting or incontinence? **YES / NO**

If YES Please give details:

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17. Do you snore or suffer from insomnia? **YES / NO**

If YES Please give details:

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18. Are there any other issues or support needs we should be aware of? **YES / NO**

If YES Please give details:

In order for us to provide adequate support for the participant we may need to ask for further information from either Social Care and Health etc. This will be done confidentially and in keeping with the 'Data Protection Act'. We will also need to keep your information on a cloud database which is confidential and only available to Spiral employees who need access to medical records and emergency contacts. Can both the participant and Carer/Guardian/Parent (as witness, or for a minor under 18 years of age) please sign your consent here below.

I (name of participant) _____ consent to Spiral exchanging my personal details

with Brighton & Hove Social Care & Health and my College/School/Day Centre or Police.

Participant Signature: _____ Date: _____

Carer's Signature: _____ Print Name: _____

Medication Administration / Supervision: (Please tick as appropriate)

Please note that as we are responsible for your health and well-being whilst on holiday with Spiral, we will either administer / Supervise / monitor all medications. Please select from the list below which is the most appropriate for yourself or the holiday maker.

1. Administration (Medication given, signed and Administered by Spiral Staff) ☐

2. Supervision (Medication administered yourself, signed & supervised by Spiral Staff) ☐

3. Monitored (Medication administered by yourself, signed on MARS sheet by you, But monitored by Spiral Staff at each time of administration) ☐

Carer's / Participant's Signature: _____