

Dr Mick Clarke
 The Apollo Education Project
 90 Old Bedford Road
 Luton
 LU2 7PD
 07788 477849
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THE APOLLO EDUCATION PROJECT LIMITED

Student Referral Form

Please complete all sections of this form in your word-processor and email to
doctormick52@gmail.com.
 Alternatively, complete in black ink and post to The Apollo Education Project Limited
 If you have any problems completing or submitting this form then please
 contact Dr Mick on 07788 477849.

Please note that each new referral will be offered a two week assessment place.

Date of Referral:		
Name of student:		
Sex: M F		Date of birth:
Nationality:		
Ethnic origin:		
Address:		
Telephone numbers:		1. 2.
Names of parents / carers:		
Telephone no. if different from above:		
Social Worker and telephone no. (if applicable):		
Connexions PA and telephone number:		
Name of placing school/LA department/ care provider:		
Contact Person:		
Address and telephone number:		
Address and named contact for invoicing purposes:		
Number of sessions required:		

EDUCATION DETAILS

Educational statement: YES / NO	Dated: Category/Description of need:
Recommendations of statement:	
Name and address of previous education provider/school:	

EDUCATION HISTORY

Details of student's educational background over last year, including summary of attendance and details of any changes in their circumstances:	
Percentage (%) of attendance prior to arrival at the Apollo Education Project	
Details of current educational provision including subjects followed, exams taken/to be taken, achievements Name and contact number of Teacher:	
Current National Curriculum key stage levels:	
Details of any emotional and/or behavioural difficulties that could impact on educational provision:	
Details of any medication / medical condition: (see consent form)	

Student's hobbies and interests:	
Details of regular appointments/activities already arranged (days/times):	
Any other relevant information concerning the student:	

Form completed by: _____

Relationship to student: _____

We require as much supportive information as possible in order to promptly process the referral.

Proposed start date: _____

Assessment meeting date: _____

Training Days

Our training days maybe different to the referring schools dates. Please ensure that you state any training days and term dates for your school with this referral.

The Next Step

Following the completion of the referral form and a visit for the student to Apollo Education Project Social Enterprise CIC, a start date will be agreed for a two week assessment period (minimum of 5 sessions to be completed by young person).

An education plan will be agreed and the students place confirmed at the assessment meeting.

The plan is then implemented and reviews take place on 6 weekly cycles.

The Apollo Education Project Limited

Consent Form 2015/2016

Apollo Education Project Social Enterprise CIC complies with the Data Protection Act 1998. All data given will be held and used in accordance with the Act.

Section 1 – Outdoor and Off Site Activities

As part of our curriculum all students regularly take part in a range of outdoor activities and off site visits. Therefore each student will need the following outdoor clothing, suitable for all weathers including wet weather: coat or jacket, trousers such as tracksuit or joggers, spare socks and trainers or walking shoes.

The kit can be left at Apollo.

Section 2 – Medical Information

Name of Doctor:	
Address and phone number of Doctor:	

Please give details of any allergies affecting your young person and/or details of any medication your young person is currently taking, including dosage and whether it can be self-administered:

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Please give details of anything which may affect fitness to participate in certain activities, or which may affect their wellbeing (e.g. recent operations, phobias, toileting difficulties, etc.):

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Please give date of last anti-tetanus injection:

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Please give details of any special dietary requirements your young person has:

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Section 3 - Photography and filming

As part of our curriculum, we use role play and rehearsal which may be filmed for the students use. We also take photographs for students to add to their record of work.

Signed:

Relationship:

Parent/Guardian/Person with Parental Responsibility

Date:

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Student Emergency Plan

Name of student:		
Sex: M F	Age:	Date of birth:
Address:		
Name of parents / carers:		
Telephone numbers:	1. 2.	
Name and address of emergency contact if parent/carer not available:	Name: Address:	
Telephone numbers of emergency contact:	1. 2.	
Social Worker name and telephone no. (if applicable):	Name: Telephone Number: Address:	

It is important that we have contact numbers for every student in case of an emergency.

Checklist:

Referral Form Tick if completed

Emergency Plan Form Tick if completed