### Parental Medical Questionnaire - To inform the Early Years Additional Resource (EYAR) request for:

1. **Targeted Individual Support (TIS) 2**
2. **Education, Health and Care (EHC) needs Assessment**
3. **Specialist provision (Observation and Assessment, Resourced provision or special school)**

In order to ensure appropriate medical advice and information are sought and received regarding your child, it would be helpful if you could complete this questionnaire. The questionnaire should be submitted with any of the applications referred to above (a-c).

**For TIS2 applications (a) and requests for specialist provision (c),** it will enable your views to be considered regarding any possible health needs, whilst also enabling you to give consent for information to be shared as you wish.

**As part of the EHC assessment process (b),** the Local Authority is required to seek medical advice. This is because we need to determine whether or not your child’s progress in education is affected by a medical condition. The medical advice for this purpose is co-ordinated by the Community Paediatrician (setting/school Doctor). This can be done by using the information you provide on this questionnaire and liaison with relevant medical professionals.

If the EYAR Request continues to an EHC Needs Assessment, we will share this information with the Community Paediatrician who will consider the medical information you provide. In most cases completion of the questionnaire provides all of the information we require, which means a medical appointment will not be necessary unless you specifically request one. If the Community Paediatrician concludes that a medical examination is recommended, the health service will contact you directly to offer an appointment

It would therefore be helpful if you would complete and return this form to your child’s setting as soon as possible. If there is any confidential information you do not wish the setting to be aware of, you may wish to place this questionnaire in a sealed envelope marked private and confidential when you hand it over. Alternatively you could return it by post or email to:

Wigan Council

Special Educational Needs and Disability Team   
People Directorate: Children and Families   
Wigan Council   
P O Box 100

Wigan, WN1 3DS

[SENDSAdmin@wigan.gov.uk](mailto:SENDSAdmin@wigan.gov.uk)

**Personal Details:**

|  |  |
| --- | --- |
| Name of Child |  |
| Date of Birth |  |
| Parent(s) |  |
| Address |  |

**Medical History:**

|  |
| --- |
| Does your child have any existing diagnoses? |
|  |
| Do you have any concerns regarding your child’s health? |
|  |
| Is he/she under a consultant? |
| If so please give the consultant’s name and the name of the hospital/clinic |
|  |
| **\*Please send any reports you would like the Doctor to see when you return this questionnaire** |
|  |
| Is your child on any medical treatment? Please give details: |
|  |
| Does your child’s health pose any risk to them or to others in the setting/school environment? If so, what? |
|  |
| Is there any family medical history you would like to share? |
|  |
| Please list any medical professionals/therapy services involved with your child (e.g. SALT – name of therapist etc.) |
|  |

**Parental Responsibility Declaration**

|  |  |  |
| --- | --- | --- |
| We/I **am satisfied** that the information I have provided identifies my child’s current health/medical needs. | **YES** | **NO** |
| We/I **do** give permission for the school medical service to contact our child's GP/Consultant for further advice/ information, if appropriate | **YES** | **NO** |
| We/I am concerned that my child may have additional medical needs that have not been identified.  If the outcome of the EYAR Request is to consider an EHC needs assessment, I would like the Community Paediatrician to consider if it would be appropriate for my child to see a Paediatrician as part of their EHC Needs Assessment. | **YES** | **NO** |
| If an Education Health and Care Plan is issued, we/I give consent for the EHC Plan to be shared with my child’s GP | **YES** | **NO** |
| **Please confirm GP name and address:** | | |

Signed…………………………………………………………(Parent/Guardian)

Print Name ……………………………………………………(Parent/Guardian)

Date…………………………