INCLUSION QUESTIONNAIRE

Please help us find out about any physical or mental health condition, impairment or difficulty that may affect your child's learning. We have a legal duty to take steps to improve outcomes for students identified with a disability. The Department of Children, Schools and Families have developed a number of questions to help schools to obtain relevant information from all parents. The information will be used by us to promote the wellbeing of disabled children and address any difficulties they face in all aspects of school life.

Please take time to complete the form and return back to school.

We will treat what you have told us here sensitively. None of the information will be shared with other parents or pupils. The back page of this questionnaire provides more information about who this information will be shared with.

If you need help to fill in this questionnaire, please let us know.

Child's first name: ……..

Child's Surname / family name: ……..

Child's other names: ……

Date of Birth: (dd/mm/yy) ……...

Gender: (please circle) Boy Girl

Does your child have any physical or mental health condition, impairment or difficulties?

(Please circle): No - Form completed, please sign on page 4 and return to school.

Yes - Please complete the questions below:

1. **Does your child have any difficulty that affects his or her**?

	Yes	**Sometimes**	**No**	**Don't know**
A) Classroom learning	☐	☐	☐	☐
B) Interaction with his or her classmates/ peers?	☐	☐	☐	☐
C) Joining in other school activities e.g. lunchtime, breaks, social and leisure activities in school?	☐	☐	☐	☐

2. Does your child have any difficulty that affects his or her?

	Yes	**Sometimes**	**No**
a) Daily activities such as eating, dressing, communicating, moving around, going to the toilet?	☐	☐	☐
b) Taking a full part in activities at home?	☐	☐	☐
c) Taking part in activities outside the home?	☐	☐	☐

3. Has your child had an accident or trauma in the last 5 years that has seriously limited their activities either at home or school? (Please circle): No

Yes - If **yes please describe:** ……..... ……. ……. …….

4. i). Does your child have a physical or mental health condition, impairment or difficulty such as: anxiety or depression, arthritis, asthma, autism, cancer, diabetes, epilepsy, learning difficulty, physical difficulties or a severe disfigurement?

(Please circle): No Unsure Yes - **If yes please answer 4.ii:**

4.ii). Has the physical or mental health condition, impairment or difficulty gone on for a year or more (or is it likely to)?

(Please circle): No Unsure Yes

5. Has your child seen a professional (e.g. paediatrician, psychologist) because of the physical or mental health condition, impairment or difficulty?

(Please circle): No Yes - If yes **please circle** who you have seen:

Educational psychologist / doctor / counsellor / paediatrician / therapist / other (please specify):

What was the condition identified / diagnosed? ……... ……. ……. …….

6. **Overall, how does the physical or mental health condition, impairment or difficulty affect your child in their daily life? (Please tick one only)**

No difficulty. Medication/aids/equipment allow my child to take a full part in home, community and school activities. ☐

Occasionally it interferes with everyday activities but only in a minor way - there is an impact but it is trivial or small ☐

There are particular times and situations when activities are regularly stopped or limited because of the difficulty. ☐

It frequently affects a number of daily activities. ☐

The impact is felt on almost all activities every day. ☐

7. **How is your child affected as a result of their physical or mental health condition? Impairment or difficulty? Please tick any that apply to your child.**

Mobility: getting around in or outside the home ☐

Hand function: holding and touching ☐

Personal care: has difficulty washing, going to the toilet, dressing ☐

Eating and drinking : has difficulty eating or drinking by themselves or sickness or lack of appetite ☐

Incontinence: has difficulty controlling the passage of urine and/or faeces ☐

Communication: speaking and/or understanding others ☐

Learning: has special education needs ☐

Hearing ☐

8. Does your child take any medication, use any physical aids or require any special diet or supplements for any physical or mental health condition, impairment or difficulty? Please tick any of the below options that may apply to your child.

Medication (including inhaler) ☐

Physical Aids (including hearing and walking aids but NOT glasses) ☐

Special Diet or Supplement ☐

No Medication, Physical Aids or Diets. ☐

9. Please describe the support that your child finds particularly helpful to enable them to take part in daily activities in school, at home, or in the community e.g. access to therapy, computers, respite care, support from friends, skills training.

……
……
……
……
……
……
……
……
……
……

10. Would you like to talk about any of these issues with a member of school staff?

Yes ☐ No ☐

Form completed by: …… Parent/Guardian

Signature: …… Parent/Guardian

Contact telephone No: ……

Email address: ……

Date: ……...

Please return the form to your school in the envelope provided.