To take part in activities in our Family Hubs you will need to register with us.

Please complete all boxes otherwise the form will be returned.

|  |
| --- |
| Please indicate if applicable whether you are:  |
| Self-Registration ☐ | Early Help Services ☐ | Social Care ☐ | Community Services ☐ |
|

|  |  |  |  |
| --- | --- | --- | --- |
| Little Explores ☐Baby Explorers ☐ | Little Chefs ☐ | Baby Massage ☐ | Tea and Toast ☐ |
| Parent & Carer Panel ☐ | 1-1 Healthy Start Drop In ☐ | ACE Recovery Adult Programme ☐ | Volunteer Programme ☐ |
| Youth Connect 5in Transit ☐Youth Connect 5 Teens ☐ | Family Advice and Support Drop In☐ | Think ACE Create PACES ☐ | Chatter Time ☐ |
| Peep (Learning Together) ☐ | Virtual 1-1 Information Advice Support Service ☐ | Virtual 1-1: Breast Feeding Support ☐ | Virtual Parent and Carer Panel ☐ |

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**Privacy Statement**

I understand that the information supplied on this form may be used to identify the relevant support service available. This may include sharing the information with Sefton Family Hubs. It has been explained to me that my information will not be shared with anyone else unless I have been contacted and have agreed to this. I am aware that consent to share information is voluntary and I may withdraw my consent at any time. My information will be stored on a secure system in accordance with the Data Protection Act 1998.

**Please confirm you are happy for us to collect and use your information as set out above ☐**

If you are completing this form on behalf of a parent or carer, please tick to confirm verbal consent has been given and they have been made aware of the privacy notice. **Verbal Consent ☐ N/A ☐**

We would like to give you info about what is going on within the Family Hubs. Please indicate your communications preference. **Email ☐ Telephone Call ☐ Text Message ☐ Do Not Contact ☐**

|  |
| --- |
| **Organisation Referral Details** |
| Name |  | Job Title |  |
| Organisation |  |
| Full Address (inc. Postcode) |  |
| Telephone Number |  | Mobile Number |  |
| E-mail |  |

|  |
| --- |
| **Participants Details**  |
| First Name(s) |  | Surname |  |
| Sexuality  |  | Religion  |  |
| Number of Children ***child/children’s Name & EHM/ICS number*** |  | Any allergies |  |
| Gender |  | Date of Birth |  |
| Full Address (inc. Postcode) |  |
| Nursery/ School |  |
| Telephone Number |  | Mobile Number |  |
| E-mail |  |

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| --- |
| **Emergency Contact Details** |
| Name |  | Relation to participant  |  |
| Full Address (inc. Postcode) |  |
| Telephone Number |  | Mobile Number |  |

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| --- |
| **Ethnicity Motioning (please tick the option you identify with)** |
| **Asian** | **Black** | **Mixed Dual Heritage** | **White** |
| Bangladeshi |  | African |  | White & Asian |  | White British |  |
| Chinese |  | Caribbean |  | White & Black African |  | White Irish |  |
| Indian  |  | Other Black |  | White & Black Caribbean |  | Polish |  |
| Pakistani |  | Other Asian |  | Other Mixed |  | Other White |  |
| Traveller |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

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| **Disability Monitoring** |
| Does the participant consider themselves to have a disability? Yes / No**If you have answered YES, how would you describe your impairment (please select from the options below)** |
| Physical Impairment |  | Visual Impairment |  | Learning Disability |  | Hearing Impairment |  |
| Long term illness |  | Other (please specify) |  | Mental health  |
| **Is there any information or adaptions that the staff need to be aware of?** |

|  |
| --- |
| **Other Relevant information** |
| Any other relevant information would be useful for the facilitators, and why you believe the participant will benefit from the programme.  |
|   |
|  |

**Once we have received the referral form and you have indicated the programme you would like a member of staff from the Family Hub will contact the family to provide them with more details.**

**Please forward all completed forms via email to:**

**Intervention Team email:** **Seftonfamilyhubdeliveryteam@sefton.gov.uk**