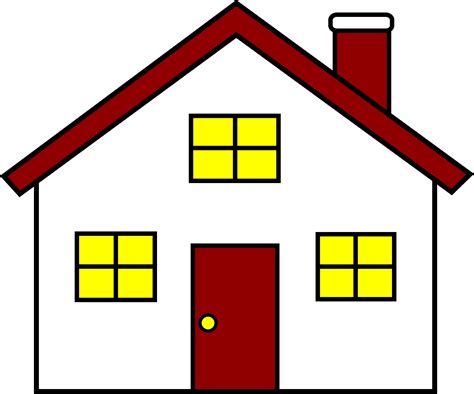
**BREATHING SPACE**

SOCIAL ACTIVITIES SCHEME FOR PEOPLE WITH LEARNING DISABILITIES

**MEMBERS REGISTRATION FORM**

Please complete this form and return it to Breathing Space. If you need more space please write on another sheet of paper. We would rather have more information than not enough.

**Your name** ................................................................................................................................



**Date of Birth** ............................................................................................................

**Usual Address** .........................................................................................................



.................................................................................................................................

**Postcode** ..................................................

**Tel Number**...........................................................**Mobile** ........................................................

**Any other contact tel number** ..............................................Who is this................................

**EMERGENCY CONTACTS** – Do you live on your own? **YES or NO**......................................

If YES - Please give name of your main Carer/Supporter.......................................................

If you live with another person please give their name here.....................................................

**Relationship to you** (Parent, Sister/Brother, Support Worker) ..............................................

**Carer’s Address and Tel No**. if different to yours ..................................................................

.................................................................................................................................................

**Care Manager or Community Nurse** (if any) ........................................................................

**YOUR HELP NEEDS**



MOBILITY Can you walk without help? INDOORS **YES/NO** STAIRS **YES/NO**

OUTDOORS  **YES/NO** SAY WHAT HELP YOU NEED........................................

..................................................................................................................................

Do you ever need a wheelchair?.............................................................................

Can you use the toilet unaided? **YES/NO/I NEED SOME HELP** if you need help



please write down what help you need.....................................................................

How do you indicate when you want the toilet? **VISUALLY/VOCALLY/SIGNS**

**(This form is confidential when complete)**

**FOOD/DRINK** Breathing Space activities may include social eating and drinking.

ARE THERE ANY FOODS OR DRINKS YOU MUST AVOID OR TAKE ONLY IN MODERATION?



**YES/NO** if YES please give details.......................................................................

..................................................................................................................................

**MONEY** - Do you need help with money when out on activities? **YES/NO/A LITTLE**



Say what help you need............................................................................................

**HEALTH NEEDS**

MEDICAL INFORMATION (for our use in an emergency and when planning activities)

DO YOU SUFFER FROM ANY MEDICAL CONDITION BELOW?

**ALLERGIES** – such as milk products,nuts,eggs, penicillin, sticking plaster etc :

……………………………………………………………………………………

ASTHMA **YES/NO**

EPILEPSY **YES/NO**

What treatment is required during/after seizure? Medication Required?

..................................................................................................................................

..................................................................................................................................

HEART COMPLAINTS **YES /NO**

DIABETES **YES/NO**

HEARING LOSS (DEAFNESS - Hearing Aid) **YES/NO**

SENSORY LOSS (Blind or Partial Sight – Spectacles) **YES/NO**

ARTHRITIS **YES/NO**

ANY BEHAVIOUR CHARACTERISTIC WHICH BREATHING SPACE WILL NEED TO

KNOW ABOUT AND MANAGE WHEN ON ACTIVITIES?

ANY MEDICATION WHICH YOU WILL USUALLY NEED TO HAVE WITH YOU

ON ACTIVITIES?

WHAT HELP WILL YOU NEED WITH IT?

**(This form is confidential when complete)**

**DOCTOR’S NAME** .....................................................................................................................

**MEDICAL PRACTICE ADDRESS**.............................................................................................

...................................................................................................................................................

**TELEPHONE NUMBER OF SURGERY**....................................................................................

Do you agree Breathing Space may contact your doctor in an emergency? **YES/NO**

**Please write here any further details which will help Breathing Space to understand your needs.**

I have given the details correctly

**Signed by** ....................................................................................................................(member)

The details on the form are correct

**Signed by**....................................................................................................(Carer or Supporter)

**Date** ................................................................................

**WOULD YOU LIKE US TO SEND DETAILS OF ACTIVITIES & NEWSLETTERS ETC BY:**

**EMAIL/POST (Please circle)**

**(This form is confidential when complete)**