

**PLEASE USE BLOCK CAPITALS**

NAME OF SERVICE USER (CLIENT NAME)

DATE OF BIRTH

NAME OF PARENT/GUARDIAN

HOME ADDRESS

TELEPHONE NUMBERS:

HOME

MOBILE

WORK

NAME OF PERSON TO CONTACT IN CASE OF AN EMERGENCY

TELEPHONE

PLEASE GIVE A DESCRIPTION OF THE SERVICE USER'S DIAGNOSIS / SPECIAL NEEDS

**PLEASE USE BLOCK CAPITALS**

PLEASE GIVE DETAILS OF ANY MEDICATION THE SERVICE USER REQUIRES AND / OR INFORMATION REGARDING ANY CLINICAL PROCEDURES THE SUPPORT WORKER MAY BE REQUIRED TO CARRY OUT:


DOES THE SERVICE USER DISPLAY ANY BEHAVIOURS THAT THE SUPPORT WORKER NEEDS TO BE AWARE OF?


DOES THE SERVICE USER HAVE ANY ALLERGIES / SPECIAL DIETARY REQUIREMENTS?


PLEASE PROVIDE DETAILS OF ANY OTHER SPECIFIC REQUIREMENTS:


# private client

## CONFIDENTIAL REGISTRATION FORM

Scholefield Road Day Centre • Archway • London • N19 3ES  
T: 020 7686 0253 F: 020 7686 0254 [www.specialpeople.org.uk](http://www.specialpeople.org.uk)



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PLEASE GIVE AN OUTLINE OF THE OBJECTIVES OF THE SUPPORT PACKAGE / DETAILS OF ACTIVITIES THE SUPPORT WORKER WILL BE UNDERTAKING WHILST WITH THE SERVICE USER:


### PLEASE STATE TIMES AND DAYS OF SERVICE REQUIREMENT

MONDAY

TIMES:

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TUESDAY

TIMES:

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WEDNESDAY

TIMES:

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THURSDAY

TIMES:

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FRIDAY

TIMES:

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SATURDAY

TIMES:

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SUNDAY

TIMES:

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DATE SERVICE IS TO COMMENCE:

TO END:

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SIGNATURE:

DATE:

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