



Lindengate Short Programmes Registration Form

BUDZ

A 6-week nature-based course supporting young people 13-15yrs in personal growth and resilience

Please note if you are under 18yrs you must have your Parent/Relevant Person Representative provide consent. See Page 6.

Referral Type (please tick)	Self-Referral	Professional Referral
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Office Use Only:	Date Registration Form Received:	
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Title:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
First name:	If other please specify:
Preferred name:	Age:
Surname:	Date of Birth:
Address:	Home tel:
	Mobile:
Postcode :	Email:

Common Mental Health Condition if diagnosed:

Depression	Obsessive Compulsive Disorder	Panic Disorders	Phobia	Generalised Anxiety Disorder	Common MH Disorders not otherwise specified	No Diagnosis
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Lindengate, The Old Allotment site, Wendover Rd, Aylesbury HP22 6BD or
email: referrals@lindengate.org.uk or phone 01296 622443

Overall how do you rate your wellbeing?



How do you hope to improve your wellbeing at Lindengate?

Our nature-based activities are designed to increase confidence, wellbeing and learn new skills. What do you hope to achieve?

Health

Please let us know of any medical conditions, allergies, epilepsy, mobility, sight, hearing, substance misuse issues or anything else you think may be relevant which could affect your ability to do physical activities or work in a group, so we may ensure your safety and wellbeing is maintained. Please tell us about any other specific support you require:

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<p>Please see Pg 8 for Epilepsy Sheet (if required)</p>

Behaviours

Please indicate the issue(s) that the person you referred that is causing you concern	
Risky behaviours	
Aggressive behaviours	
Challenging behaviours	
Relationship breakdowns	
Conflict within the family	
Emotional distress	
Social isolation	
Other	

Risks associated with the person being referred	√	Comments
Do they have a history of violence towards staff?		
Do they have a history of carrying offensive weapons?		
Do they have a history of making false and or malicious allegations/complaints about staff?		
Do they have a history of inappropriate sexual behaviour or comments?		

<p>When was the last time the person presented with these behaviours?</p>
<p>What support are they getting now or in the past to address the behaviour?</p>

In the event of an accident or incident please tell us who we should contact:

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Emergency Contact 1:

Contact name:	Address:
Relationship to you:	
Home tel:	Postcode:
Mobile no:	Email:

Emergency Contact 2:

Contact name:	Address:
Relationship to you:	
Home tel:	Postcode:
Mobile no:	Email:

Health Consent

Please tick either box below to indicate your consent or that you do not consent to Lindengate holding the above health information about you.

- I consent I do not consent

Video / Photograph Consent

It is our policy that where we are planning to use an image (photograph or video) for materials in the public domain, consent must be obtained by the appropriate person. Image consent can be changed or withdrawn at any time by notifying a member of staff. However, we cannot withdraw images already published.

Participant Consent

Please tick the boxes below to indicate your consent:

- Anonymous photos where face cannot be seen or is obscured? Yes No
- Identifiable photos of face? Yes No
- Video interview face-to-face? Yes No

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Collecting Your Feedback

Lindengate regularly collects feedback and comments from users of our services. This information provides evidence of the impact of our services which is used to support fundraising and publicity.

Please tick to agree, or not, to us collecting this information.

I consent I do not consent

Keeping in touch in accordance to Data Protection (GDPR)

All information provided on the registration form and in any further correspondence with Lindengate will be treated as confidential and will not be disclosed to any third party outside of Lindengate without consent from the person. If we are under a duty to disclose or share your data in order to comply with any legal obligation e.g. safeguarding children or vulnerable adults, acts of terrorism or money laundering we are obliged to cooperate.

From time to time Lindengate may need to contact you (for example, if there was to be a closure due to weather etc.) If you agree to us contacting you for this purpose please tick to indicate that you consent:

I consent I do not consent

Signed by Programme Participant		Date	
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Parent or Relevant Person Representative Consent Form (if applicable)

Consent form to be completed by the Parent/Relevant Person Representative for participants Under 18yrs

Name of Young Person attending Lindengate programme:	
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I give permission for the person named above to attend **BUDZ** at Lindengate Mental Health Charity next to Dobbies Garden Centre, HP22 6BD

Parent or Relevant Person Representative Details

Title:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other If other please specify:
First name:	
Preferred name:	Age:
Surname:	Date of Birth:
Address:	Home tel:
	Mobile:
Postcode :	Email:

Signed by Representative:		Date	
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Equal Opportunities Monitoring Form

Participant Name:

How would you describe your ethnic origin? (The following categories are recommended by the Commission of Racial Equality.)

A White

British

Irish

Any other white background please write

Here: _____

B Mixed

White and Black Caribbean

White and Black African

White and Asian

Any other mixed background please write

Here: _____

C Asian or Asian British

Indian

Pakistani

Bangladeshi

Any other Asian background please write

Here: _____

D Black or Black British

Caribbean

African

Any other Black background please write

Here: _____

E Chinese or other ethnic group

Chinese

Any other ethnic background please write

Here: _____

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Epilepsy Personal Care Record

Date:

Name	
Type and description of seizure	
Normal seizure length	
Frequency of seizures	
Date of last seizure	
Known triggers	
Normal recovery time	
Prescribed medication (name and time taken)	
Medical alert card/bracelet	
Any history of status epilepticus	
Any emergency medication to be administered	

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CONFIDENTIAL

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