|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|

|  |  |
| --- | --- |
|  C:\Users\w_frog\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.MSO\CC9F6316.tmp |   |
|  | **Authority** |

 |  |

**Early Notification to Local Authority**

This notification is made in accordance with Section 36 of the Children and Family Act 2014

|  |  |
| --- | --- |
| Child’s Full Name: | DOB: |
| Address: | Age:Male / Female |
| Parent/Carer’s Name: | Educational Placement Name (if appropriate) |
| Address (if different): | Parent/Carer’s phone number: |
| Email Address: | First Language:  |
| Referrer:Tel:Date: | Is the Child Looked After? If so, name of social worker: |
| Please provide a brief description of the child’s needs, or attach a recent report |
| Specialist services involved (please tick as appropriate)* Consultant paediatrician
* Speech and language therapy
* Physiotherapy
* OT
* Audiology
* Early years health and development team
* Ophthalmic
* Children’s hearing service
* ENT
* Children’s community nursing team
* Other
 |

 **AGREEMENT OF PARENTS / CARERS**

**Parent / Carer declaration:**

* I confirm that the health professional has discussed this notification with me and I support the decision to refer
* I confirm that all personal information included on this form (name, address etc.) is correct
* I am happy for the Local Authority to contact me following receipt of this early notification
* I agree with information from health being shared with the Local Authority and your child’s setting when appropriate, as detailed in the attached Fair Processing notice
* I give consent for the Early Learning & Childcare Team to contact the nursery setting/childminder to seek an update with a view to possible observation, consultation and assessment of my child if this is felt appropriate
* I understand that information will be shared and stored on a data base with the Local Authority
* I would like to be kept informed of training, events and consultations relating to children with Special Educational Needs and Disabilities via email, or post.

Parent / Carer’s name(s)……………………………………………………………………

Signature(s): …………………………………………………………………………..

Date: ………………………………………………………………………..

**Please return to:**

**Special Educational Needs and Disability Team
Wigan Council
P O Box 100**

**Wigan WN1 3DS Tel 01942 486136**

**Maire.Robinson@wigan.gov.uk**