**Spark Contact Form**

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| **Young Person’s Name:** |  |
| **Young Person’s Date of Birth:** |  |
| **Young Person’s Address:** |  |
| **Young Person’s Mobile Number:** |  |
| **Young Person’s Email Address:** |  |
| **Young Person’s School:** |  |
| **Young Person’s GP Surgery:** |  |

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| --- | --- |
| **Parent/Carers Name (if known):** |  |
| **Parent/Carers Address (if known):** |  |
| **Parent/Carers Contact Number (if known):** |  |
| **Parent/Carers Email Address (if known):** |  |

**Which Spark Group would the young person like to attend:**

* **Bishops Stortford** (for those living in East Herts)
* **Watford** (for those living in Watford)

1. **Does the young person have any medical conditions, disabilities or allergies that we need to be aware of or make adjustments for?**

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1. **Please provide some information in regards to the reason the young person would benefit from attending the Spark group.**

* **What are their current needs?**

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**Data Protection and Confidentiality**

Hertfordshire Mind Network adheres to the Data Protection Act 2018’s principles of good information handling and the EU General Data Protection Regulation 2018.

Please indicate below if you consent to us collecting, recording and processing your personal data for the purpose of providing you with support and to ensure your health, safety and wellbeing. We will use your information appropriately and in line with our Privacy Policy which you can find on our website.

Your details will not be shared with anyone else without your consent. If you have any concerns or questions about how your personal data is collected and used, please ring us on **020 3727 3600** or email us at [info@hertfordshiremind.org](mailto:info@hertfordshiremind.org). Please note that without your consent, you will not be able to access Hertfordshire Mind Network’s services.

Where information is given in confidence that Hertfordshire Mind Network believes poses a risk to the client, a risk to other people, a risk to the safety and welfare of a child, or is against the law, we reserve the right to disclose that information to a relevant third party.

Do you consent to us collecting, recording and processing your personal data for the purpose of providing you with support and to ensure your health, safety and wellbeing?

**Yes**

**No**

|  |  |
| --- | --- |
| **Young Person’s Signature:** |  |
| **Parent/Carers Signature (if appropriate):** |  |

**Young Person Equal Opportunity Data**

**Age:**

12-14  15-16  17**-**18  18-24  25-34  35-44  45-54  55-64  65-74  75-84

85-89  90+  Prefer not to say

**Gender:**

Male  Female  Gender-fluid  Non-binary  Prefer not to say

If you prefer to use your own term, please specify here:

**What is your sexual orientation?**

Heterosexual  Gay Man  Lesbian/Gay Woman  Bisexual  Prefer not to say

If you prefer to use your own term, please specify here:

**What is your ethnicity?**

Ethnic origin is not about nationality, place of birth or citizenship, it is about the group to which you perceive you belong to.

**White**

English  Welsh  Scottish  Northern Irish  Irish  British

Gypsy or Irish Traveller  Prefer not to say

Any other white background – please specify:

**Mixed/multiple ethnic groups**

White and Black Caribbean  White and Black African  White and Asian  Prefer not to say

Any other mixed background, please specify:

**Asian/Asian British**

Indian  Pakistani  Bangladeshi  Chinese  Prefer not to say

Any other Asian background, please specify:

**Black/ African/ Caribbean/ Black British**

African  Caribbean  Prefer not to say

Any other Black/African/Caribbean background, please specify:

**Other ethnic group**

Arab  Prefer not to say

Any other ethnic group, please specify:

**What is your religion or belief?**

No religion of beliefBuddhist  Christian  Hindu  Jewish  Muslim  Sikh  Spiritual  Prefer not to say

**Disability**

**Are your day-to-day activities limited because of a health problem or disability, which has lasted or is expected to last for at least 12 months**

None  Behavioural/Emotional  Long-term illness of condition

Mental Health condition  Physical impairment (such as mobility)  Learning disability

Sensory impairment (such as sight or hearing)

Other disability description  - please specify:

**Do you have Autistic Spectrum Disorder?**

Yes  No  Awaiting Diagnosis

**Are there any adaptations or adjustments you require from us as a result of this?**

**Do you have caring responsibilities? If yes, please tick all that apply:**

None  Primary carer of a child/children (under 18)  Primary carer of a disabled child/children

Primary carer of a disabled adult (18 and over)  Primary carer of an older person

Secondary carer (another person carries out the main caring role)  Prefer not to say