This form is to be completed by the prospective Special Guardians

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| --- |
| 1 PERSONAL DETAILS |
| Name |  |
| DOB |  | Height |  | Weight |  |
| Address |  |
| Telephone |  | Supervising Social Worker |  |
| Approval Date |  |
| 2 MEDICAL DETAILS *(Give dates & details including names of consultants & hospitals where possible)* |
| List any ongoing medical conditions you have: |
|  |
| a) Would you class yourself as being in good health? | Yes | No |
| Specify |
| b) At present are you attending a doctor or any hospital clinic? | Yes | No |
| Specify |
| c) Have you had any illnesses, accidents or operations? | Yes | No |
| Specify |
| d) Have you been referred for any medical opinions, advice, x-rays or other investigations? | Yes | No |
| Specify |
| e) Have you been prescribed any medicines or other treatments by your own or any other doctor? | Yes | No |
| Specify |
| f) Have you suffered from depression, anxiety or any nervous or psychiatric illness? | Yes | No |
| Specify |
| g) Have you any disabilities i.e. sight, hearing etc? | Yes | No |
| Specify |
| h) Do you, or have you suffered from epilepsy, fits or blackouts? | Yes | No |
| Specify |
| i) Do you suffer, or have you suffered from chest conditions i.e. TB, bronchitis or pleurisy? | Yes | No |
| Specify |
| j) Have you had any illnesses or injuries which have kept you off work/education for an extended time? | Yes | No |
| Specify |
| k) How many cigarettes do you smoke a day? |  |
|  l) How much alcohol do you drink per week? (units per week) |  |
| m) Are you, or have you ever been addicted to drugs? | Yes | No |
| Specify |
| n) Is there any other health matter you wish to tell us about? | Yes | No |
|  |
| 3 CHILD(REN)/YOUNG PEOPLE RELATING TO SPECIAL GUARDIANSHIP APPLICATION (*write the names, dates of birth and indicate whether the child/young person is looked after or not)* |
| Child/young person’s name |  | Is the child/young person Looked After? | Y/N | DOB |  |
| Child/young person’s name |  | Is the child/young person Looked After? | Y/N | DOB |  |
| Child/young person’s name |  | Is the child/young person Looked After? | Y/N | DOB |  |
| I agree that the Medical Adviser may make further enquiries of my GP or other doctors who have treated me about matters in this Declaration.Signature: Date: |
| This form when completed will be sent to your GP for his/her comments. It will then be sent to the Medical Adviser (Fostering) who may wish to make further enquiries of your GP or any other doctors who have treated you about matters in this Declaration. |
| GP’s name |  | Telephone Number |  |
| Surgery address |  |
| Doctors Comments: |
| Once completed, please return to: **Fostering Team, Halford House, 91 Charles Street, Leicester, LE1 1HL** |
| Medical Advisors Comments: |