

**Consent Information**

**Parent / Carer (with parental responsibility)**

* I have been given and understand the leaflet on Information Sharing and in signing this form I am agreeing to receiving the service and that my personal information and that of the children I have parental responsibility for, can be shared with other agencies as required, to ensure I receive the best service and support.
* I agree to Northumberland County Council sharing my household data with other government departments for the purpose of research or funding requirements *(please cross out if you do not agree to this data sharing)*.

***Signed………………....…………Name………..…………...Date…………..***

***Signed……………………………Name………..…………...Date…………..***

***Signed……………………………Name………..…………...Date…………..***

***Signed…………………………….Name………..…………..Date…………..***

**Please ensure all adults in the household have signed this agreement of service form**

This is your family’s assessment and can be completed with the **whole** family to include all their views including all the children in the household.

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| --- | --- | --- |
| **Today’s Date:** | **Family Address:** | **Telephone Number:** |
| **Family Name:** | **Post Code:** | **Email Address:** |

**Children and young people this Early Help Assessment if for:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Dob/EDD** | **Gender** | **Education Provider** |
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**Who else lives in your house?**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **DoB/EDD** | **Gender** | **Relationship to Child/ Young Person** | **Parental Responsibility** | **Ethnicity** | **Language** | **School** | **Disability** | **EHCP Y/N** | **SEND** |
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**Who is important to your family?**

(All those individuals aged over 18 outside the family home)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **DoB** | **Gender** | **Relationship** | **Could they be part of a network of support?** |
|  |  |  |  | Yes / No / Unsure |
|  |  |  |  | Yes / No / Unsure |
|  |  |  |  | Yes / No / Unsure |
|  |  |  |  | Yes / No / Unsure |
|  |  |  |  | Yes / No / Unsure |

**Services involved with the family (please complete as fully as possible):**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name and Role** | **Address and Contact Details** | **Contributed to the Assessment?** |
| GP |  |  | Yes / No |
| Nursery / School(s) |  |  | Yes / No |
| Nursery / School(s) |  |  | Yes / No |
| Health Services (Health Visitor) |  |  | Yes / No |
| Health Services (Midwife) |  |  | Yes / No |
|  |  |  | Yes / No |
|  |  |  | Yes / No |

**What is happening that has led to this assessment / current issues?**

* Think about the ACES, Adverse Childhood Experiences.

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| --- | --- |
|  | **Make sure you also think about:**   * Health * Education * Relationships * Parenting Styles * Environment |

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| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |
| 6. |  |

**Please record in detail, not bullet points. Use additional sheets if required.**

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| **What are we worried about?** | **What’s working well?** | **What needs to happen?** |
|  |  |  |
| **Immediate Actions:** | | |
| **How have spoken to the child or children or are their thoughts/ experiences included?** | | |

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| ***Make sure you capture the child's voice, or observations for a non-verbal child. Children can be invited to the TAF meeting, they can write their views on the form or use signs of safety tools. Encourage other members of the TAF to use tools with the children they are connected with to ensure the meeting captures all of the children’s voices.*** |

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| ***When scaling 0-10 remember that 0 is when you are really worried and 10 is when you don’t have any worries.*** |

**Scaling the situation, the child, young person, family and initiator can all scale the worry.**

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| --- |
| **Name of person scaling: -**  I currently rate the situation at \_\_\_\_\_\_\_\_\_ Because  **Name of person scaling: -**  I currently rate the situation at \_\_\_\_\_\_\_\_\_ Because  **Name of person scaling: -**  I currently rate the situation at \_\_\_\_\_\_\_\_\_ Because  **Name of person scaling: -**  I currently rate the situation at \_\_\_\_\_\_\_\_\_ Because  **Name of person scaling: -**  I currently rate the situation at \_\_\_\_\_\_\_\_\_ Because |

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| --- | --- |
|  | TAF Meeting ( within 6 weeks) date: |
|  | Lead Professional: |
|  | **Who has completed this form?** |
|  | Author Name and Role: |
|  | Author Address |
|  | Author Telephone No: |
|  | Author Email Address: |
|  | Date form completed |

:

Once you have completed this form, if you have a secure email, please send a copy of the EHA and email the TAF meeting dates to the Early Help Coordinators (EHC) via: [eha@northumberland.gov.uk](mailto:eha@northumberland.gov.uk)