

Additional child form

Child's first name(s)

.....

Child's surname

.....

Date of birth

Boy

Girl

Age

Carer's contact telephone number

.....

Is your child in the care of the Local Authority, or the subject of a care order or in Foster care?

Yes No

Please tell us your child's condition or diagnosis if known

Date of diagnosis if known

•	
•	
•	
•	

Does your child have care needs relating to incontinence? Yes No

Has your child had to stay overnight in hospital because of their condition in the last 12 months?

Yes No

Tick the rate of **Disability Living Allowance (DLA)** your child has been awarded. If this is your first application you must send us copies of your award letter. We cannot return original documents to you.

Care component

Mobility component

My child is not getting DLA

High rate care

High rate mobility

Have not applied

Middle rate care

Low rate mobility

Waiting for a decision

Low rate care

Have been refused

Please tell us the medication needs of your child.

How often

•	
•	
•	

Please tick the treatment or therapy your child receives.

How often

Physiotherapy

Occupational therapy

Speech /language therapy

Psychologist/Psychiatrist /CAMHS

Audiology /Ophthalmology

Chemotherapy/Radiotherapy

Paediatrician /Consultant

Other

.....

