

**SLEEP ACTION CHILD REGISTRATION FORM**

Please fill in both sides, sign & return to: School Health Team, The Balfour, Foreland Road, Kirkwall, KW15 1NZ or ork.schoolnurses@nhs.scot

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| **Child information** |
| First name: |
| Last name : |
| Address: |
| Postcode: |
| Date of birth: |
| Male Female |
| Does your child have a diagnosis? |
| Is your child on any medication? |
| School/nursery |
| Number of siblings |
| Does your child have their own bedroom? Yes No |
| Are other agencies involved (for example health professionals, social work)? |

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| **Parent / carer information** |
| Name: |
| Phone number: |
| Email address: |
| **About your child’s sleep** |
| Are the sleep problems Settling Night waking Early morning waking |
| Please briefly describe the sleep problem. For example, how long it has lasted, what your child does and how it affects them and the family. |
| Would you be interested in sleep support by phone? Yes No |
| **How we use and store your information** |
| The information on this form will be stored in line with our privacy policy which you can view on our website at <https://sleepaction.org/privacy-policy/>  Do you consent to this? Yes No |
| Signature of parent / carer: |
| Date |

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