** Directorate for Children,**

 **Young People and Families**

**FORM CR1 (Child Missing Education)**

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| PLEASE TRY TO COMPLETE ALL SECTIONS OF THIS FORM  |
| **Date referral made**: |
| **Pupil Surname:****Alias:** | **Pupil First Name :****Pupil Middle Name:** |
| **Date of Birth:** | **UPN No (If Known) :** |
| **Address: Current 🞏 Last Known 🞏** **Post code :** | Names of parents / guardians (full names please)DOB if known**1. …………………………………..………….****2. …………………………………………….****Relationship to child:…………………………** |
| **Contact No Home:** |
| **Contact No Mobile:** |
| **Any Other Contact No’s:** |
| **Are there any known concerns related to staff safety in visiting this family/address: YES 🞏 No 🞏**  |
| **Ethnicity:** | **Gender:** | **Year Group:** |
| **Name of School:**  **Contact name in school:** |
| **On Roll:** **YES 🞏 No 🞏**  | **Is this the current school** **🞏 OR Last known school 🞏** |
| **Date last attended school:** |
| **Is this child / young person currently: (please tick if known)** |
| Looked After? |  | A Refugee/ Asylum Seeker? |  |
| Subject to a Child Protection plan? |  | From a Travelling Family? |  |
| In Temporary Accommodation? |  | Subject to a CAF?  |  |
| **Are any of the following agencies known to be currently involved with this child / family? (please tick)**(please can you provide contact names and telephone numbers on the additional comments box overleaf) |
|  Social Care (Social Services) |  | Education Psychology |  |
|  Education Welfare |  | School Nurse (when was the child last seen?) |  |
| CAMHS |  | Youth Offending Team |  |
| Other ( please detail) |  |
| **Please provide** **details of any siblings below (if known) –** only those of compulsory school age |
|  **Name** |  **DOB** |  **School**  |
|  |  |  |
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|  |  |  |
| **ADDITIONAL CONCERNS / COMMENTS: -** Please add more info on an additional sheet if required |
| **Recent action taken by school/ referrer** |
|  | YES | NO | **Dates / Details** |
| **Telephone calls made** |  |  |  |
| **Letters sent (please attach copies)**  |  |  |  |
| **Home visits made** |  |  |  |
| **Name of referrer :** | **Service :** | **Contact no :** |
| **Signed ……………………………………………… Date …………………….…** |
| **Please send this referral form to:** to CME@barnsley.gov.uk **Tel: 01226 773545 SEND BY EGRESS** |