**CHILD CONCERN FORM**

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| **Is this a child you are concerned may be AT RISK OF SIGNIFICANT HARM (as per Highland Child Protection Guidance). Please tick.** | **No** |
| **Yes** |
| **If yes, confirm below,**  **Name & office of Social Worker or Police Officer spoken to:**  **Date:**  **Time:** | |
| **FORM Must be sent to Named Person (+ SW if Child Protection Concern)**  **SENT TO:** | |
| **Name:** | |
| **Agency:** | |
| **Date & time of incident:** | |

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| FORM COMPLETED BY: | | |
| **Name** (print)**:** |  | |
| **Job Title & Agency:** |  | |
| **Contact Details:** |  | |
| **Signature:** | |  | | --- | | **Date:** | | |
| **Full name/dob of the CHILD you are concerned about or (name/address label)**  (use Mother’s surname if unborn) | | **Name of Parent/Date of birth and address or**  **(name/address label if available)** |
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| **Describe the issues which give you cause for concern, and why.**  **Include how many occasions or how long this has been happening, and the possible impact on the child.** | | |
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| **Comment if you know the views of the child and/or parents about this.** | | |
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| Describe any assistance that the child or any family member might require  (e.g. English not first language, interpreter required, mobility issues, deaf, visually impaired etc.) | | |
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| Information Sharing. | | |
| **Is consent to share this information required Yes**  **No**  **Is the parent /carer/child aware of the information**  **If YES who has given consent and how has it been obtained? sharing Yes  No**  **If NO what is the reason for not requiring consent?** | | |

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| Section 2.7 – Health and other Agencies Distribution List Prior to submitting this form, please indicate below those people you have included in the distribution: |
| |  |  |  | | --- | --- | --- | | **Sent to** | **Name** | **Date Sent** | | **Child Protection Advisor (CPA)**  ***Must be sent to CPA in own locality*** |  |  | | **CPA (Raigmore)**  ***Must be included for unborns*** |  |  | | **Midwife** |  |  | | **Health Visitor** |  |  | | **Head/Guidance Teacher** |  |  | |  |  |  | | **School Nurse** |  |  | | **GP** |  |  | | **Social Worker** |  |  | | **CPN** |  |  | | **CAHMS** |  |  | | **Paediatrician** |  |  | | **Adult Mental Health** |  |  | | **Specialist Nurse ie Diabetes, epilepsy, cystic fibrosis, learning disability** |  |  | | **Allied Health Professional**  ***(state which)*** |  |  | | **Other Professionals** |  |  |   **Signature:****Date:**  **\*Named Person:**  **Midwife – pre -birth to 10 days; Health Visitor – 10 days to School; Primary Head Teacher – Primary Education; Head Teacher or Guidance Teacher – Secondary Education** |