**CHILD CONCERN FORM**

|  |  |
| --- | --- |
| **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:**  |

|  |
| --- |
| 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)** |
|       |       |
| **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.** |
|       |
| **Comment if you know the views of the child and/or parents about this.** |
|       |
| 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.) |
|       |
| 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?** |

|  |
| --- |
| Section 2.7 – Health and other Agencies Distribution ListPrior 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** |