

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Name/Address of School (if applicable): \_\_\_\_\_

Date of Assessment: \_\_\_\_\_

I have assessed the above named child. According to the assessment results, the child meets the Department of Education and Science criteria for **resource teaching support** as stated in Circular 08/02 for the condition / disability indicated below. The assessment was carried out with the informed, written consent of the parent(s) who have been made aware of the results of the assessment.

*please tick  
one box only*

Physical Disability	
Hearing Impairment	
Visual Impairment	
Emotional Disturbance and/or Behavioural Problems	
Severe Emotional Disturbance	
Mild General Learning Disability	
Moderate General Learning Disability	
Severe or Profound General Learning Disability	
Borderline Mild General Learning Disability	
Autism/Autistic Spectrum Disorders	
Specific Learning Disability	
Children with special educational needs arising from an assessed syndrome ( <i>please specify</i> .....	
Specific Speech and Language Disorder	
Multiple Disabilities ( <i>please specify</i> .....	

Does this child have **care** needs that require the support of a **special needs assistant** (Yes / No)

If 'Yes' please describe the child's care needs \_\_\_\_\_

Please indicate the level of care you recommend:

**Part-time:** No. of hours per week  **Full-time:**

**Signature:** \_\_\_\_\_ **Profession:** \_\_\_\_\_

**Date:** \_\_\_\_\_