COMBAT CLASSROOM

Combat Classroom - ALTERNATIVE PROVISION REFERRAL FORM

1. REFERRING ORGANISATION DETAILS

School / Organisation Name:

Address:

Main Contact Name:

Role:

Email:

Phone Number:

Is the student currently on roll at your setting? □ Yes □ No

2. STUDENT DETAILS

Full Name:

Date of Birth:

Year Group:

Gender:

Home Address:

Parent/Carer Name(s):

Contact Number(s):

Email:

3. REASON FOR REFERRAL

(Please tick all that apply)
□ At risk of permanent exclusion
□ Permanently excluded
□ Behavioural difficulties
□ Emotional / mental health needs
□ Disengagement from education
□ Attendance concerns
□ Other (please specify): _____

Detailed Reason for Referral:
(Include background, triggers, patterns of behaviour, and previous interventions)

4. EDUCATIONAL INFORMATION

Current Attainment Levels (if known):
Attendance % (last 12 months):
Exclusion History (fixed/permanent):

Strengths / Interests:

Barriers to Learning:

5. SPECIAL EDUCATIONAL NEEDS (SEND)

Does the student have SEND? □ Yes □ No

If yes:

Primary Need:

□ SEMH □ ASD □ ADHD □ Learning Difficulty □ Other: _____

EHCP in place? □ Yes □ No
(If yes, please attach)

Support currently in place:

6. SAFEGUARDING INFORMATION (MANDATORY)

DSL Name (Referring School):

DSL Contact Details:

Current Safeguarding Status:
□ None
□ Early Help
□ Child in Need (CIN)

□ Child Protection Plan (CP)
□ Looked After Child (LAC)

Please provide details of any safeguarding concerns:
(Include risk of harm, exploitation, violence, self-harm, or other vulnerabilities)

7. RISK ASSESSMENT (MANDATORY)

Has the student demonstrated:

Physical aggression: □ Yes □ No
Verbal aggression: □ Yes □ No
Weapon carrying: □ Yes □ No
Absconding: □ Yes □ No
Substance misuse: □ Yes □ No
Criminal involvement: □ Yes □ No

If YES to any, provide details:

Known triggers:

De-escalation strategies that work:

8. MEDICAL INFORMATION

Any medical conditions? □ Yes □ No
If yes, details:

Medication required during sessions? □ Yes □ No

Any physical limitations or injuries relevant to combat activity:

9. PROVISION REQUEST DETAILS

Requested Start Date:

Placement Type:

□ Part-time □ Short-term intervention □ Reintegration programme

Desired Outcomes:
(e.g. behaviour improvement, attendance, reintegration)

10. PARENT/CARER CONSENT

Has the parent/carer been informed of this referral? □ Yes □ No

Do they consent to this referral? □ Yes □ No

Parent/Carer Signature: _____

Date: _____

11. REFERRER DECLARATION

I confirm that:

- All information provided is accurate and complete
- All relevant safeguarding and risk information has been shared
- The parent/carer is aware of this referral

Name: _____

Signature: _____

Date: _____

Upon completion of this document please email across to combatclassroomltd@gmail.com

12. FOR OFFICE USE ONLY

Referral Received Date:

Reviewed By:

Outcome:
□ Accepted □ Rejected □ Further Information Required

Notes:

IMPORTANT:
Incomplete referrals or missing safeguarding/risk information will not be processed.