



SENNIES PROFILE



Full name*:

Location*:

Driver*: Yes ☐ Manual ☐ Automatic ☐
No ☐

Enhanced DBS*: Yes ☐ No ☐ Renewal date:

Enhanced DBS number*:

DBS Automatic Renewal update service*: Yes ☐ No ☐

Live in/out*: Live in ☐ Live out ☐ Either ☐

About me*:

What SENNIES say:

INTERNAL USE ONLY

Junior Sennie ☐ Sennie ☐ Super Sennie ☐

SEN / Additional Needs Experience:

1. Want to gain experience 2. Somewhat experienced 3. Moderately experienced 4. Highly experienced

	1	2	3	4
ADHD <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism / Autistic Spectrum Condition <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Challenging Behaviour <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colostomy Bag Users <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D/deaf Persons <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Down Syndrome <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dyscalculia <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dyslexia <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dysphagia <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dyspraxia <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorders / Difficulties <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fragile X Syndrome <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Global Developmental Delay <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Conditions <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pathological Demand Avoidance <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prader-Willi Syndrome <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Profound and Multiple Learning Disabilities <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Care Needs <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rare Chromosome Disorder <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rare Disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory Processing Disorder <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social, Emotional and Mental Health Needs <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trauma (Emotional) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic Brain Injury <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual Impairments <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair Users <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Please Specify): <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Special Educational Needs & Childcare Work Experience

Please list your most recent and/or most relevant experience working with children and/or those with Special/Additional needs

Position held*:

Age(s) worked with*:

Days/hours*:

Dates worked*:

Additional Needs present*:

N/A ☐

Responsibilities*:

Proudest achievement in role*:

Reason for leaving*:

Position held*:

Age(s) worked with*:

Days/hours*:

Dates worked*:

Additional Needs present*:

N/A ☐

Responsibilities*:

Proudest achievement in role*:

Reason for leaving*:

Position held*:

Age(s) worked with*:

Days/hours*:

Dates worked*:

Additional Needs present*:

N/A ☐

Responsibilities*:

Proudest achievement in role*:

Reason for leaving*:

Practical Experience, Training and Certifications:

1. Yes / Obtained 2. Need to renew 3. Willing to obtain

	1	2	3
Administering Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism Awareness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care Certification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Gaze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First Aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First Aid (Pediatric)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Makaton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PECS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PEG Feed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People Moving and Handling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safeguarding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CACHE Qualifications (Please Specify): <div></div>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SENNIES Training (Please Specify): <div></div>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Please Specify): <div></div>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Teaching Experience*:

Qualified Teacher ☐

Teaching / Learning Support Assistant ☐

Years of experience

Years of experience

1:1 / 2:1 support ☐

Homeschool support ☐

Years of experience

Years of experience

Tutor ☐

Vocational Teacher ☐

Years of experience

Years of experience

e.g. Drama, Dance or Sports teacher etc.

N/A ☐

Highest level of education*:

Hobbies and Special Interests*:

Additional information:

Please use this space to tell us any further details or important information you'd like our SENNIES families to know about you or your experience