



C-Scheme Self Registration Form

16 - 24 Years

Free and confidential service to get condoms

We will try and sort you out with a card and condoms as quickly as possible, although we might need to talk to you further.

First Name _____ Last Name _____

Address _____

Postcode _____ Mobile No _____

Date of birth ___ / ___ / _____ Age _____

Are you: (please tick)

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Male transgender <input type="checkbox"/> Female transgender <input type="checkbox"/> Prefer not to say <input type="checkbox"/> I identify as _____	Sexual Orientation <input type="checkbox"/> Gay <input type="checkbox"/> Straight / Heterosexual <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Prefer not to say <input type="checkbox"/> I identify as _____
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Are you: (please tick)

<input type="checkbox"/> Living in OR leaving public care (A)	<input type="checkbox"/> Not in Education, employment or training (J)
<input type="checkbox"/> Using mental health services (B)	<input type="checkbox"/> Black or minority ethnic (E)
<input type="checkbox"/> Misusing drugs or alcohol (B)	<input type="checkbox"/> Disabled/have a learning disability (F)
<input type="checkbox"/> A young parent (D)	<input type="checkbox"/> Excluded from school / college (G)
<input type="checkbox"/> LGBTQ	<input type="checkbox"/> Homeless/in temporary accommodation (H)
	<input type="checkbox"/> None of the above (X)



What is your ethnicity? _____

Prefer not say

Are you currently sexually active? Y / N Are you in a relationship? Y / N How old were you when you first had sex? <input type="checkbox"/> Under 13 <input type="checkbox"/> 13-15 <input type="checkbox"/> 16+ How old is your current boyfriend or girlfriend? _____ Have you had sex without giving your consent? Y / N Have you had sex without using protection in the last week? Y / N Have you had a chlamydia screen in the last 6 weeks? Y / N	Do you have latex allergy Y / N What method of contraception do you use? <input type="checkbox"/> Condoms <input type="checkbox"/> Depo injection <input type="checkbox"/> Implant <input type="checkbox"/> No contraception <input type="checkbox"/> The pill <input type="checkbox"/> Other _____
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Would you like to talk with a sexual health worker?	<input type="checkbox"/> Today	<input type="checkbox"/> Maybe later	<input type="checkbox"/> No
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Section to be completed by a Sexual Health Worker / Professional
Please follow your safeguarding procedures if there are concerns

C-Scheme given Y / N C-Scheme number _____

Condoms _____ Lube _____

Name: _____ Role: _____
(PRINT)

Signature: _____ Venue: _____

Date: ___ / ___ / _____ Time: _____ :

