

CHILD'S DETAILS

First Name Middle Name
 Last Name Known Name
 Male Female DNI/ PASSPORT
 Date of Birth / /
 Required Start Date / /

Are there any celebrations or festivals that you would like us to celebrate as part of your culture?

.....

Nationality

First Language

Spoken at home English Other (please specify)

Who has parental responsibility for the child?

.....

Does your child attend any other setting or child minder?

If yes please name

.....

PRIMARY CARER

Relationship to child

First Name

Last Name

Email Address

Address

..... Postcode

Employer Name Work Tel

Fixed Term End Date (if applicable) Mobile

Home Tel DNI/ PASSPORT

2nd CONTACT

Relationship to child

Emergency contact? Yes No DNI/ PASSPORT

First Name

Last Name

Email Address

Address

..... Postcode

Employer Name Work Tel

Fixed Term End Date (if applicable) Mobile

Home Tel Mobile

IN CASE OF EMERGENCIES

In case of an emergency please provide two alternative contacts who you authorise to collect your child

Name Relationship to child Tel

Name Relationship to child Tel

■ DOCTORS DETAILS

Name of Doctor
Centre
Address
Postcode Tel

■ PERMISSION GRANTED FOR (please tick ✓)

- Prescribed Medication Administer Medication Face painting
 Sun Cream Emergency Medical attention Nappy cream

I do / do not give my permission for appropriate images of my child to be printed for use within HOPSCOTCH as a record of their learning and to be displayed within the preschool. I understand that electronic copies of images will be destroyed once no longer relevant.

I do / do not give my permission for appropriate images of my child to be used in the press, in promotional material, HOPSCOTCH website, social media (including the school's social media accounts).

I do / do not give my permission for outings /forest school excursions.

■ ALLERGIES (please list)

.....
.....

■ DIETARY

Please list any special requirements
.....
Any other special needs / preferences of which we should be aware?

■ MEDICAL

My child has no known medical conditions

My child has the following medical conditions (please list)

.....
.....

■ IMMUNISATIONS

My child's immunisations are up to date: Yes No Date of last immunisations

*Waiver form if necessary

■ SESSIONS

Please choose the sessions you require in the grid below

	Mon	Tues	Wed	Thu	Fri
08.00-17.00					
08.00-15.00					
08.00-13.00					
08.00-12.00					

Signed.....

Name Date / / 21