

Sacred Steps Pre-school

Application form for Sessional Childcare

CONFIDENTIAL ESSENTIAL INFORMATION

CHILD'S SURNAME..... FIRST NAME(S).....

DATE OF BIRTH..... RELIGION.....

ADDRESS..... ETHNICITY.....

.....POST CODE.....

TELEPHONE NUMBER..... GENDER (M/F).....

MOTHER

NAME OF MOTHER.....

ADDRESS.....

POST CODE.....

TEL NO. (HOME).....

(MOBILE).....

WORK PLACE.....

ADDRESS.....

.....POST CODE.....

TEL NO.....

FATHER

NAME OF FATHER.....

ADDRESS.....

POST CODE.....

TEL NO. (HOME).....

(MOBILE).....

WORK PLACE.....

ADDRESS.....

.....POST CODE.....

TEL NO.....

PARENTAL RESPONSIBILITY

NAME.....

ADDRESS.....

.....POST CODE.....

LEGAL CONTACT

Name.....

Address.....

.....Post Code.....

LANGUAGE SPOKEN AT HOME.....

CHILD'S POSITION IN FAMILY (E.G. ELDER OF TWO CHILDREN = 1/2).....

SIGNED (PARENT/GUARDIAN)..... DATE.....

EMERGENCY CONTACT DETAILS

THE PRE-SCHOOL WILL CONTACT PARENTS OR LEGAL GUARDIANS, IF UNAVAILABLE WE REQUIRE **TWO** ADDITIONAL CONTACTS.

EMERGENCY CONTACT

NAME.....
ADDRESS.....
.....POST CODE.....
TEL NO. (HOME).....
(MOBILE).....
RELATIONSHIP TO CHILD.....

EMERGENCY CONTACT

NAME.....
ADDRESS.....
.....POST CODE.....
TEL NO. (HOME).....
(MOBILE).....
RELATIONSHIP TO CHILD.....

CHILD'S DOCTOR

NAME.....
ADDRESS.....
.....POST CODE.....
TEL NO.....
HEALTH VISITORS NAME.....

PREVIOUS NURSERY/PLAYGROUP

NAME.....
ADDRESS.....
.....POST CODE.....
TEL.NO.....

HAS YOUR CHILD BEEN IMMUNISED AGAINST ANY OF THE FOLLOWING:-

DIPHTHERIA..... TETNUS..... POLIO..... MEASLES..... MUMPS.....
RUBELLA..... WHOOPING COUGH..... HIB..... MENINGITIS.....

IS THERE ANY MEDICAL HISTORY OF YOUR CHILD OR MEMBER OF IMMEDIATE FAMILY (PLEASE STATE REALTIONSHIP) SUFFERING FROM:-

TB..... CONVULSIONS..... ECZEMA..... HAY FEVER..... ASTHMA.....

DOES YOUR CHILD HAVE ANY ALLERGIES? (PLEASE STATE).....

DOES YOUR CHILD HAVE ANY SPECIFIC NEEDS E.G. HEARING PROBLEMS, HIV, DIETARY REQUIREMENT

.....

MEDICAL CONSENT

I GIVE PERMISSION FOR ANY INJECTIONS, OPERATIONS OR HOSPITAL TREATMENT WHICH MAY BE NECESSARY IN THE EVENT OF MY ABSENCE. PLEASE STATE ANY MEDICAL PROCEDURES PROHIBITED BY FAMILY, RELIGIOUS OR CULTURAL BELIEFS.....

.....

SIGNED.....(PARENT/GUARDIAN) DATE.....