

# Booking Form



Child's full name: \_\_\_\_\_

Is your child known by any other name (Please specify): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Start Date: \_\_\_\_\_

Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Post code: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Religion/ethnicity\* (Optional) \_\_\_\_\_

Parent (1) Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Place of work: \_\_\_\_\_

Parent (2) Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Place of work: \_\_\_\_\_

Who has Parental Responsibility (PR) for the child? \_\_\_\_\_

Who has legal contact with the child (Name & address?) \_\_\_\_\_

Does the child reside at any other residence (Name & address?) \_\_\_\_\_

## Emergency contact details:

Person (1) Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Person (2) Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Person (3) Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Named person who may collect the child (If not the parent) \_\_\_\_\_

Password: \_\_\_\_\_

Does your child have any additional needs? (Please specify) \_\_\_\_\_

Is your child receiving any additional support? (Please list name & contact numbers)

Name and age of any siblings: \_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_

Sessions required:-

Sessions	Monday	Tuesday	Wednesday	Thursday	Friday
Full Day					
Morning					
Afternoon					

Tick sessions required. Please note sessions are non transferable. Additional sessions are charged at the daily rate.

In a medical emergency, if we cannot get in touch with you or any people listed on your emergency contact. Do you give permission for us to act on your behalf seeking any necessary emergency advice or treatment? YES  NO

Name, address and contact Number of your GP or Medical Centre: \_\_\_\_\_

\_\_\_\_\_ Contact Number: \_\_\_\_\_

Name and address of Health Visitor: \_\_\_\_\_

Does your child have any medical conditions (Please specify) YES  NO

Does your child have any continuous medication (Please specify) YES  NO

Are your child's immunisation up to date? YES  NO

Are there any medical procedures, which are prohibited by your religious beliefs? YES  NO

Is there anything else you feel that we or a hospital (emergency) will need to know? YES  NO

**If your child requires medication during the day a separate form will need completing.**

Does your child suffer from any of the following:-

Eczema / Asthma / Hay fever / Breathing Difficulties: \_\_\_\_\_

Hearing difficulties / Grommets: \_\_\_\_\_

Speech difficulties: \_\_\_\_\_

Heart / Circulation problems: \_\_\_\_\_

Epilepsy / Fits: \_\_\_\_\_

Nose Bleeds / Headaches / Migraines / Dizzy Spells: \_\_\_\_\_

Frequent use of the toilet / other toilet or stomach problems: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Does your child have any distinguishing birth marks? \_\_\_\_\_

Does your child have any dietary needs? (Please specify) \_\_\_\_\_

Are there any foods that your child must NOT have? (Please specify) \_\_\_\_\_

Does your child have any allergies? (Please specify) \_\_\_\_\_

Is there anything that frightens your child? (Please specify) \_\_\_\_\_

I/we confirm that the information given on this form is accurate. I/we accept that it is my/our responsibility to keep the nursery up to date with any changes to my/our child's records.

Where both parents have parental responsibility, both parties need to sign the application form.

Parent (1) Signature: \_\_\_\_\_ Parent (2) Signature: \_\_\_\_\_

Deposit paid: - £ \_\_\_\_\_ Date: \_\_\_\_\_