

BUTTERFLIES DAY NURSERY - REGISTRATION FORM

INFORMATION ON THIS FORM IS CONFIDENTIAL. ACCESS IS GIVEN TO STAFF AND OTHER EARLY YEARS PROFESSIONALS ONLY ON A NEED TO KNOW BASIS.

CHILD DETAILS:

FULL NAME GENDER MALE / FEMALE
DATE OF BIRTH

ADDRESS: Please give the address of both parents if they live seperately.

MOTHERS DETAILS

NAME
House No/name
Street
Town
County
Postcode
HOME TEL
MOBILE
WORK PLACE
WORK TEL
EMAIL

FATHERS DETAILS

NAME
House No/name
Street
Town
County
Postcode
HOME TEL
MOBILE
WORK PLACE
WORK TEL
EMAIL

DOES THE FATHER HAVE LEGAL PARENTAL RESPONSIBILITY? YES

I.E. Parents were married at birth, Fathers name is on the Birth certificate, Parents married since the birth
IF NO TO THE ABOVE, MOTHER NEEDS TO GIVE COLLECTION PERMISSION BELOW

STATUS: MARRIED CO-HABITING SINGLE DIVORCED WIDOWED (please circle)

WHO HAS LEGAL CONTACT?

I.E. People who the child lives with or who has day to day care and control of the child

NATIONALITY ETHNIC ORIGIN
HOME LANGUAGE RELIGION

PLEASE STATE ANY RELIGIOUS CELEBRATIONS CELEBRATED AT HOME THAT YOU WOULD LIKE US TO CELEBRATE AT NURSERY

DO YOU CLAIM ANY FUNDING: YES NO
If YES please state which:

EMERGENCY CONTACT:		NAME	TEL:
COLLECTION PERMISSION: (Father if required)	Relationship to child	1st <input type="text"/>	<input type="text"/>
	Relationship to child	2nd <input type="text"/>	<input type="text"/>
	Relationship to child	3rd <input type="text"/>	<input type="text"/>

HEALTH: ALLERGIES YES NO SPECIAL NEEDS YES NO

ALLERGIES / SPECIAL NEEDS - IF YES- ATTACH DETAILS INCLUDING ANY OTHER AGENCIES INVOLVED

DOCTOR:
SURGERY:
TELEPHONE: HEALTH VISITOR:
DIETARY NEEDS:

IMMUNISATIONS: Please tick if immunised

DIPHTHERIA TETANUS MENINGITUS C POLIO
WHOOPING COUGH HIB MMR PCV

EMERGENCY CONSENT:

In the case of your child needing medical attention, Do you give consent for any treatment to be given by the ambulance or hospital personnel.

<input type="checkbox"/> YES	I DO GIVE MY CONSENT	SIGN AND DATE	
<input type="checkbox"/> NO	I DO NOT GIVE MY CONSENT		

IF NO, WHICH TREATMENT WOULD YOU SAY NO TO I.E. BLOOD TRANSFUSION

PERMISSIONS:

<input type="checkbox"/> 1	I give consent for staff and other agencies such as Ofsted Inspectors, Area SENCO, Health Visitor, to carry out and record observations on my child for the purpose of developmental assessment.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> 2	I give consent for students to carry out and record observations on my child for the purpose of study.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> 3	I give consent for photographs to be taken and filed for the purpose of developmental records.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> 4	I give consent for photographs to be displayed in the Nursery.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> 5	I give consent for photographs to be used for brochures and other marketing publications, and to be used for quality assurance evidence.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> 6	I give consent for the application of sun screen when necessary	<input type="checkbox"/> YES	<input type="checkbox"/> NO
		IF YES: (please circle)	
		<input type="checkbox"/> OWN SUPPLY ONLY	
		<input type="checkbox"/> OWN AND NURSERY	
<input type="checkbox"/> 7	I give consent for my child to go on outings within walking distance of Nursery.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> 8	I will provide nappy cream and give permission for it to be applied when required	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> 9	I accept that the Nursery staff prepare bottle feeds for my child at the nursery, with the powder I have provided	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> 10	If NO to 9, I take responsibility for the contents of any bottle feeds I provide for my child to have at nursery.		
	SIGN AND DATE		

OTHER INFORMATION:

SIBLINGS:	NAME	AGE	Will your child attend another setting? If Yes which setting?	
1				
2			WHERE DID YOU HEAR ABOUT US?	
3				

I AGREE TO ABIDE BY THE NURSERY POLICIES AND TERMS & CONDITIONS AND THAT THE INFORMATION ON THIS PAGE IS CORRECT AND THAT I MUST INFORM NURSERY OF ANY CHANGES

SIGNED:	DATE: