WHITSTABUBBLES REGISTRATION FORM

PERSONAL DETAILS

CHILDS NAME :

CHILDS ADDRESS :

POST CODE :

DOB : AGE :

GENDER : - MALE / FEMALE

NAME OF OTHER CHILD CARE SETTING IF ANY :

FIRST LANGUAGE : -

GP NAME :

GP ADDRESS :

IF YOU ANSWER YES TO ANY OF THE FOLLOWING THREE QUESTIONS YOU MUST COMPLETE MEDICAL FORM

DOES YOUR CHILD HAVE ANY MEDICAL CONDITIONS YES / NO

IS YOUR CHILD ON ANY MEDICATION : - YES / NO

ANY ALLERGIES OR INTOLERANCES : - YES / NO

DOES YOUR CHILD HAVE ANY SPECIAL DIETARY REQUIRMENTS : - YES / NO

IF YES PLEASE EXPAND

CHILDS RELIGION AND/OR CULTRUAL IDENTITY :-

APART FROM PERSON 1&2 WILL ANYONE ELSE BE COLLECTING CHILD FROM NURSERY?

*IF YES PLEASE COMPLETE RELEVENT PERSON FORM YES / NO

PLEASE TELL US ABOUT ANY EDUCATIONAL NEED(S) AND/OR DISABILITIES YOUR CHILD HAS

HEALTH VISITORS NAME :

HEALTH VISITORS PHONE NUMBER :

PLEASE GIVE ANY ADITIONAL INFORMATION YOU FEEL WHITSTABUBBLES SHOULD KNOW : -

PARENTS AND/OR GUARDIAN

PERSON 1

NAME :

ADDRESS :

POST CODE :

EMAIL ADDRESS :

PHONE :

MOBILE -

HOME -

WORK -

OCCUPATION :

RELATIONSHIP TO CHILD :

RELIGION AND/OR CULTRUAL IDENTITY :-

PARENTS AND/OR GUARDIAN

PERSON 2 (IF RELEVENT)

NAME :

ADDRESS :

POST CODE :

EMAIL ADDRESS :

PHONE :

MOBILE -

HOME -

WORK -

OCCUPATION :

RELATIONSHIP TO CHILD :

RELIGION AND/OR CULTRUAL IDENTITY :-

FUNDING

DO YOU REQUIRE A FUNDED PLACE AT NURSERY IF SO PLEASE TICK : -

- [ ] 2-YEAR FUNDING
- [ ] 3-4 YEAR OLD 15 HOURS UNIVERSAL
- [ ] 30 HOURS

OTHER PLEASE EXPAND

I UNDERSTAND THAT FEES ARE INVOICED HALF TERMLY IN ADVANCE AND SHOULD BE PAID IN ADVANCE BY THE FIRST DATE OF COLLECTION FOR THE HALF TERM AS DETAILED ON THE INVOICE. SHOULD PAYMENT NOT BE RECEIVED ONE WEEK AFTER THE FIRST COLLECTION IN ANY TERM , I UNDERSTAND THAT MY CHLD WILL NO LONGER BE ACCEPTED AND I WILL BE ADVISED ACCORDINGLY. I ACCEPT THAT ANY COSTS INCURRED IN THE COLLECTION OF OUTSTANDING FEES WILL BE MY/OUR RESPONSIBILLITY AND WILL BE ADDED TO THE CAPITAL DEBT.

NAME :

SIGN HERE

THE INFORMAITON I HAVE GIVEN IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

NAME :

SIGN HERE

OFFICE USE ONLY

REQUIRES MEDIAL FORM - Y / N

MEDICAL FORM RECIVED - Y / N

RELEVENT PERSON FORM REGISTERD - Y / N

RELEVENT PERSON FORM RECIVED - Y / N

DIVERSITY QUESTIONAIRE COMPLETED - Y / N

CONSENT FORM COMPLETED Y / N

NOTES