Child Registration Form

Medlock Day Nursery
270 Lee Street
Oldham
OL8 1BG
0161 526 5645
www.medlockdaynursery.com

PARENT/CARER DETAILS

Parent/Carer 1:

Name:_____ Mr/Mrs/Ms/Dr/Other:_____

Address:_____

Postcode:_____ Telephone Number: _____

Parental Responsibility? Yes ☐ No ☐

Employers Name:_____ Work Number: _____

Address:_____

Postcode: _____ Mobile Number: _____

Email Address: _____ (Home/Work)

_____ (Home/Work)

Parent/Carer 2:

Name:_____ Mr/Mrs/Ms/Dr/Other:_____

Address:_____

Postcode:_____ Telephone Number: _____

Parental Responsibility? Yes ☐ No ☐

Employers Name:_____ Work Number: _____

Address:_____

Postcode: _____ Mobile Number: _____

Email Address: _____ (Home/Work)

_____ (Home/Work)

Who does the child live with? _____

Does anyone else hold Parental Responsibility for this child? (If yes, please detail)

_____

AUTHORISED TO COLLECT

Please provide details of any other persons who have permission to collect your child

Full Name:_____ Contact Number: _____

Relationship to child: _____ Password: _____

Full Name:_____ Contact Number: _____

Relationship to child: _____ Password: _____

Please provide a photograph of anyone listed to be kept on your child's file, this will be used for verification purposes only

CHILD DETAILS

Full Name:_____ EDD/Date of Birth:_____

Known as:_____ Gender: ☐ Male ☐ Female ☐ Unknown

Ethnic Origin:_____

First Language:_____ Other Languages: _____

Birth Certificate seen and copied? ☐ Funding code: _____

ATTENDANCE

Please indicate your required booking pattern

	Morning 7.30am—1.00pm	Afternoon 1.00pm—6.00pm	Full Day 7.30am—6.00pm
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

Start date: _____ **Full time/Term time**

MEDICAL DETAILS

Doctors Name:_____

Doctors Address: _____

Telephone Number:_____

Health Visitor:_____

Telephone Number:_____

Are all immunisations up to date?

Yes ☐ No ☐

If no, please state exceptions:_____

_____

Does your child have any Additional Needs we need to be aware of?

_____

_____

Does your child have any medical needs?

_____

_____

Does your child have any dietary requirements?

_____

_____

Does your child have any allergies?

_____

_____

Are you and/or your family receiving support from the following agencies?

Paediatrician ☐ Social Services ☐

Speech and Language ☐

Family Support ☐

Signature:

Email: