



CHRISTCHURCH INFANT SCHOOL REGISTRATION FORM

CHILD'S SURNAME	FORENAME (s)
Date of Birth	SEX (M/F)
HOME ADDRESS	
POSTCODE	
HOME TELEPHONE	

1) PARENT/GUARDIAN AT ABOVE ADDRESS SURNAME (Mr/Mrs/Miss/Ms) FORENAME RELATIONSHIP TO CHILD MOBILE TELEPHONE EMAIL	2) PARENT/GUARDIAN AT ABOVE ADDRESS SURNAME (Mr/Mrs/Miss/Ms) FORENAME RELATIONSHIP TO CHILD MOBILE TELEPHONE EMAIL
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<i>Please complete the following section should one parent be living away from the child's home address</i>	
SURNAME (Mr/Mrs/Miss/Ms)	RELATIONSHIP TO CHILD
FORENAME	IS THERE A LEGAL ORDER IN PLACE?
HOME ADDRESS	IF YES, PLEASE GIVE DETAILS INCLUDING ACCESS RIGHTS
MOBILE TELEPHONE	
HOME TELEPHONE	
EMAIL	

TO ENABLE US TO CONTACT YOU IN CASE OF AN ILLNESS/EMERGENCY, PLEASE STATE YOUR USUAL DAYTIME PLACE AND TELEPHONE NUMBER. PLEASE GIVE ADDITIONAL CONTACTS WHO MUST LIVE WITHIN TRAVELLING DISTANCE OF THE SCHOOL AND WILL BE TELEPHONED IN THE ORDER GIVEN.

NAME, HOME ADDRESS & HOME TELEPHONE NUMBER	RELATIONSHIP TO CHILD	DAYTIME PLACE & TELEPHONE NUMBER IF DIFFERENT FROM HOME ADDRESS AND HOME TEL. NO.	MOBILE NO.

USUAL MODE OF TRAVEL (CAR/BUS/WALK)

NAME OF CHILD'S DOCTOR

ADDRESS

TELEPHONE NO.

MEDICAL CONDITIONS

SPECIAL EDUCATIONAL NEEDS

NATIONALITY

COUNTRY OF BIRTH

RELIGION

ETHNIC ORIGIN

FIRST LANGUAGE

HOME LANGUAGE

NAME AND ADDRESS OF PREVIOUS SCHOOL/PLAYSCHOOL

ARE YOU A TRAVELLING FAMILY? YES/NO

Gypsy/Roma Irish Heritage Housed New Traveller Circus Fairground Bargee (Circle as appropriate)

ARE YOU A CURRENT MEMBER OF THE REGULAR ARMED FORCES? YES/NO

SIBLINGS IN INFANT/JUNIOR SCHOOL.

IS CHILD IN CARE OF LA (FOSTERED) ?

EMERGENCY MEDICAL TREATMENT

If your child has an accident or suffers an illness whilst at school, we need to have your permission for him/her to receive emergency medical treatment if necessary. This consent covers the whole period your child spends at Christchurch Infant School.

Of course, in the event of an emergency, every effort would be made to contact you and a full list of names, addresses and emergency telephone numbers is taken on every visit outside of school.

Please complete and sign below:-

NAME OF CHILD

I consent to medical treatment being given to my child in the event of an accident or illness in school.

Signature of parent/guardian

Date