



Stannington Infant School  
Breakfast & After School Club



## Registration Form

Date of Registration \_\_\_\_\_

<b>Child's Full Name</b>			
<b>Home Address</b>			
<b>Date of Birth</b>		<b>Age</b>	

	<b>Parent/Carer Details</b>	<b>Parent/Carer Details</b>
<b>Name</b>		
<b>Address if different from child's</b>		
<b>Home Telephone</b>		
<b>Mobile Number</b>		
<b>Daytime Number</b>		

<b>Name(s) of Person(s) having parental responsibility for child</b>	
<b>Who does the child live with?</b>	

<b>Signature(s) of Parent(s)/Carer(s)</b>		
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For Club Use

Date child first used club:

Date child stopped using club:



## Stannington Infant School Breakfast & After School Club



### Medical Form

<b>Child's Full Name</b>	
<b>Date of Birth</b>	
<b>Who has parental responsibility for this child</b>	

#### Medical Information:

<b>Name of Child's Doctor</b>	
<b>Surgery Address</b>	
<b>Telephone Number</b>	

<b>Does your child have any know medical problems? Yes <input type="checkbox"/> No <input type="checkbox"/></b>
<b>If so, give full details</b>

<b>Record of Immunisation</b>	<b>Date of immunisation</b>
Polio/Diphtheria/Tetanus/Pertossis Hib/Meningitis C	
MMR	

	Yes /No	If Yes please provide details
<b>Does your child have any special requirements e.g. diet, allergies, learning difficulties, mobility, disability?</b>		
<b>Does your child have any conditions requiring medical treatment, including medication, that we need to know about?</b>		
<b>Is your child allergic to any medication?</b>		
<b>Any other information (continue overleaf)</b>		

<b>Emergency Medical Treatment</b>		
In the event of your child needing emergency medical treatment while in our care, they will be taken to hospital by a First Aider. Members of staff will make all reasonable effort to contact you.		
	<b>Yes</b>	<b>No</b>
<b>I consent to emergency medical treatment necessary during attendance at Breakfast and After school club</b>		
<b>I authorise club staff to sign any written consent forms required by the hospital authorities if any delay in getting consent is considered by the doctor to endanger my child's life</b>		

Form completed by: Name \_\_\_\_\_

Relation to child \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

<b>For Club Use:</b>	Where relevant has the Medical Record been filled out? Yes <input type="checkbox"/> By whom? _____ Date _____
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**It is your responsibility to ensure that this form is updated should any of the information supplied changes**