Registration Form

Child's Name: _____

Name Child is called at home: _____

Pronounced: _____

Surname: _____

Pronounced: _____

Childs PPS Number (optional): _____

Date of Birth: _____

Date First Attended this service: _____

Date cease to attend the service: _____

Name of Parents/ Guardian: _____

Parents PPS Number (optional): _____

Address: _____

_____

_____

Mobile Telephone Number: _____

Email _____

Where can you be contacted while your child is attending this Service?

Day	Morning	Afternoon
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

If Parents/Guardians are not available in an emergency name two other adults that may be contacted:

Name	Address	Telephone No:	Relationship to Child

Name of any other person/s that may collect your child other than the Parent/Guardian.

I authorise _____ and /or _____
To collect my child _____ from the service in the event of my absence.
Signed_____
Parent/Guardian

Details of Family General Practitioner:

Name:
Address:
Telephone Number:

Immunisations:

B.C.G	Diphtheria	Tetanus	Whooping Cough	Polio	HIB	MMR	Meningitis C

Does your Child have any of the following?

Medical Condition	**No**	**Yes (Specify)**
Disability	**No**	**Yes (Specify)**
Allergy	**No**	**Yes (Specify)**
Special Dietary Needs	**No**	**Yes (Specify)**
Feeding Patterns	**Likes**	**Dislikes**

What languages are spoken at home? _____

What are the names of other family members and other significant people close to your child? _____

_____

Has your child had any previous experience of early childhood services, i.e. parent & toddler groups?

_____

_____

How do you comfort your child when s/he is upset?

_____

_____

Does your child sleep well at night? _____

What can your child do for him /herself, toileting, feeding?

_____

_____

_____

Parent/ Guardian's Signature : _____

Date: _____

Agreement for Medical Treatment.

Little Acorns Children's Centre

I hereby Consent to (Child's Name):

_____

Receiving medical treatment, if a Doctor thinks is required, as an emergency and I cannot be contacted following reasonable attempts to do so prior to such treatment being administered.

Signed Parent/Guardian: _____

Relationship to Child: _____

Date: _____

Witness Signature:

Pre- school Manager / Person in Charge: _____

MEDICINE REQUEST FORM

I/We _____ (name(s) the parent(s) guardian

of_____ (name of child) Date of birth:

_____/_____/_____ being accepted by the The Little Acorns Children's Centre.

Childcare service hereby consent to:

(A) The administration of prescribed medicines by authorised staff Yes□ No□

(B) The administration of Calpol/Baby Neurofen in the event of high

temperature/emergency Yes □ NO□

My child has an allergy to Calpol/Baby Neurofen Yes□ No□

My child does not have an allergy to Calpol/Baby Neurofen Yes□ No□

Children with infectious illness should not attend a Childcare Service in the interest of all children, users and workers.

Permission to Change Clothes

I/We hereby give permission for_____ (Child's name) clothes to be changed should the need arise.

Signed: _____Parent/Guardian

Signed:_____Childcare Manager/Person in charge

Date: _____

Permission for Photography of Children.

I _____ give permission to have my Child's photograph taken and used for display and promotional purposes in and about, Little Acorns Children's Centre, Treenrevagh, Brickens, Claremorris, Co. Mayo.

Child's Name: _____

Date: _____

Policies and Procedures

I have read and understand the policies and procedures of Little Acorns Children's Centre.

I agree to adhere to these policies and procedures.

Child's name _____

Signed _____
Parent/Guardian

Date _____

Facebook Page

Please tick √ one of the following and sign

I agree to my child's picture being put on the Little Acorns Children's Centre Facebook page □

I do not agree to my child's picture being put on the Little Acorn's Children's Centre Facebook page □

Signed _____

Relationship to child _____