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| **AFTER SCHOOL CLUB Registration Form / Personal Detail Record** |
| Full Name of Child | Sex: M / F |
| Date of Birth | Birth Certificate Number |
| Home AddressTelephone Number: |
| Number of Children in Family | Child Position in Family |
| Full Names of Parents or Guardians | Occupation |
| * Father
 |  |
| * Mother
 |  |
| * Guardian
 |  |
| Parents Address if different from above |
| Father / Guardian… Place of Work Work Tel No: |
| Mother…. Place of WorkWork Tel No: |
| Emergency Contact Number: (Name and relationship to child)Email Address: |
| Name and Address of Family DoctorDoctor’s Telephone Number: |
| Health Visitor details | Telephone No: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Immunisation Record***Please mark box to indicate if the child has had the vaccination.* |  | DPT (Diphtheria/Tetanus/Polio) 2 months |  | MMR 12 – 15 months |
|  | DPT (Diphtheria/Tetanus/Polio) 3 months |  | Polio / Tetanus Booster 3 - 5 yrs |
|  | DPT (Diphtheria/Tetanus/Polio) 4 months |  | Tetanus Booster 10 - 13 yrs |
|  | Meningitis C |  | Other |
|  |  |
| Infectious Illnesses |  |  | Chicken Pox |
| Allergies or medication  |  |
| Other relevant medical information |  |
| Any special home circumstances |  |
| Are there any foods/drinks that your child is unable to consume? |  |
| Home language(s) |  |
| Religion |  |
| Parish |  |
| Has the child been baptized? | Yes / No |
| Place of Baptism |  |
| Date of Baptism |  |
| Other relevant information |  |
| **I give permission for my child to be given any emergency medical treatment that may be necessary.****Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |