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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 Address  Telephone 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 Work  Work Tel No: | | | | |
| Emergency Contact Number: (Name and relationship to child)  Email Address: | | | | |
| Name and Address of Family Doctor  Doctor’s Telephone Number: | | | | |
| Health Visitor details | | Telephone No: | | |

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| --- | --- | --- | --- | --- |
| **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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |