King's Cliffe Pre-School Registration Form

*** PLEASE COMPLETE THIS FORM IN CAPITAL LETTERS ***

YOUR CHILD'S DETAILS	
First Name(s)	
Surname	
Known Name *(if different from above)*	
Date of Birth	
Parent's Name(s)	
Address (*please use child's full address)* Post Code	
Home Telephone Number	
Mobile Telephone Number	
Email address	

Gender		MALE		FEMALE

Has an Educational Health Plan been issued in respect of your Child?	
Yes ☐	No ☐

Are any outside agencies involved in respect of your child at this time?	
Yes ☐ No ☐	If **'yes'** please use this space to advise us of which agencies. (Please use an additional sheet of paper if needed. Thank you.)

DISABILITY – Please tick relevant box/es to the left of description					
	No Disability		Problems with Hearing		Problems with Incontinence
	Problems with ASD/Aspergers		Problems with Learning		Problems with Palliative Care
	Problems with Behaviour		Problems with Medication		Problems with Personal Care
	Problems with Communication		Problems with Mobility		Problems with Vision
	Problems with Consciousness		Problems with Eating/Drinking		Other Disability, please specify:

Continued overleaf

Which sessions would you like your child to attend?

	MONDAY	TUESDAY	WEDSNESDAY	THURSDAY	FRIDAY
9:00am - 12:00pm					
12:00 - 3:00pm					

When would you like your child to start?

OFFICE USE ONLY	
Date application received	
Date of Admission	
Sessions	
Funding eligibility Date	