APPLICATION FORM

We advise discussing your needs prior to submitting your application.
Please complete in BLOCK CAPITALS.

Harrold Pre-School

PERSONAL DETAILS

CHILD'S FULL NAME:			M ◯ F ◯
CHILD KNOWN AS:		DATE OF BIRTH:	
1ST CONTACT NAME:			
CONTACT NUMBER DURING SESSION TIME:		RELATIONSHIP TO CHILD:	
ADDRESS:			
TELEPHONE:		ON FACEBOOK:	YES ◯ NO ◯
EMAIL:			
2ND CONTACT NAME:			

If second parent/carer contact has different details please fill in below.

ADDRESS:			
TELEPHONE:		ON FACEBOOK:	YES ◯ NO ◯
EMAIL:			
CONTACT NUMBER DURING SESSION TIME:		RELATIONSHIP TO CHILD:	
ALTERNATIVE CONTACT NAME:			
CONTACT NUMBER DURING SESSION TIME:		RELATIONSHIP TO CHILD:	

NAME OF PERSONS WHO HAVE LEGAL CONTACT AND PARENTAL RESPONSIBILITY:

NAME OF ANY OTHER SIGNIFICANT ADULTS IN THE HOME WHO DO NOT HAVE PARENTAL RESPONSIBILITY:

SESSION APPLICATION

I would like to apply to reserve a place for my child for (tick/select as appropriate - these days will be confirmed closer to your child's start date at the Pre-School). We will organise a home visit prior to our child starting to enable us to see your child in their home environment. We will also be able to answer any questions you may have.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
MORNING ☐ LUNCH CLUB ☐ FULL DAY ☐	MORNING ☐ LUNCH CLUB ☐ FULL DAY ☐	MORNING ☐ LUNCH CLUB ☐ FULL DAY ☐	MORNING ☐ LUNCH CLUB ☐ FULL DAY ☐	MORNING ☐ LUNCH CLUB ☐ FULL DAY ☐
Lunch Club is £6 per session			MILK OR WATER (FREE)?	MILK ◯ WATER ◯

PARENTS' WORK CONTACT DETAILS (PLEASE COMPLETE)

NAME:		TEL NO:	
COMPANY NAME & ADDRESS:			
NAME:		TEL NO:	
COMPANY NAME & ADDRESS:			
IS THERE ANY ASPECT OF YOUR WORK YOU COULD SHARE WITH THE PRE-SCHOOL?			

CHILD'S MEDICAL INFORMATION

DOCTOR'S NAME:		TEL NO:	
ADDRESS:			
DOES YOUR CHILD HAVE ANY ALLERGIES?			YES ◯ NO ◯
IF YES, Please specify:			
DOES YOUR CHILD TAKE ANY PRESCRIBED MEDICINES?			YES ◯ NO ◯
IF YES, Please specify:			
HAVE YOUR ANY CULTURAL OR RELIGIOUS WISHES THAT NEED TO BE CONSIDERED SHOULD ANY EMERGENCY ARISE?			YES ◯ NO ◯
IF YES, Please specify:			
DENTIST'S NAME:		TEL NO:	
ADDRESS:			

ASSISTANCE TO PRE-SCHOOL

Pre-School must have parents willing to volunteer to ensure it can keep operating. The committee meets once a month.

I/WE WOULD LIKE TO BECOME A 'FRIEND OF HARROLD PRE-SCHOOL'	YES ◯ NO ◯
I/WE WOULD LIKE TO JOIN THE COMMITTEE OF HARROLD PRE-SCHOOL	YES ◯ NO ◯

WE ARE KEEN TO OFFER ASSISTANCE TO THE PRE-SCHOOL IN THE FOLLOWING AREAS:

DECLARATION

I give permission for Harrold Pre-School to (tick/select as appropriate):

☐	Seek emergency medical attention for my child if necessary	☐	Apply a plaster if necessary
☐	Take my child out of school on local visits	☐	Apply sun cream
☐	Photographs to be used on our website	☐	Photographs to be used in publications
☐	Photographs to be used on our Facebook page	☐	Record details concerning my child's development to which I will have open access
☐	Take photographs that may include my child for developmental record purposes	☐	I will read and sign the retention policy, allowing pre-school to keep data about my child in line with GDPR

SIGNED:		DATE:	
NAME:			

On receipt of your application the Pre-School will consider all the details included in this application and advise you whether it is able to meet your requirements.

EQUAL OPPORTUNITIES DECLARATION

Harrold Pre-School operate an equal opportunities policy and we are requires to monitor the ethnic origin of the children using the Pre-School.

NATIONALITY:		RELIGION:	

ETHNIC ORIGIN (tick/select as appropriate):

◯	AFRICAN	◯	ASIAN
◯	CARIBBEAN	◯	UK/IRELAND
◯	CHINESE	◯	OTHER EUROPEAN Please specify:
◯	OTHER Please specify:	◯	PREFER NOT TO SAY