The Brook

ENROLMENT FORM

Childs legal surname: **Childs legal forename:**

Childs middle name(s): **Childs preferred forename:**

Gender: **Date of Birth:**

Country of Birth: **Nationality:**

Main language: **Other languages spoken in the home:**

Address:

Post code: **Home Tel:** **Preferred start date:**

Position in family: **(B for boy, G for girl, X for this child)**	**1st……2nd……3rd……4th……**
Previous school, nursery or playgroup:	
Address:	**Telephone number:**

Parents and/or Legal Guardians

Mother's name:	**Place of Work/Occupation:**
Address (if different from above):	
Work Tel:	**Extension:**
Home Tel:	**Mobile Tel:**
Main Email *(please insert one character per box):*	
Father's name:	**Place of Work/Occupation:**
Address (if different from above):	
Work Tel:	**Extension:**
Home Tel:	**Mobile Tel:**
Main Email *(please insert one character per box):*	

Emergency contacts.

Please indicate the priority of contact in case of an emergency or if you child is unwell and needs to be collected

1st Name: **Home:**……..
Relationship to Child: **Work:**…….....
Mobile:…….

2nd Name: **Home:**……..
Relationship to Child: **Work:**…….....
Mobile:…….

3rd Name: **Home:**……..
Relationship to Child: **Work:**…….....
Mobile:…….

Medical Information

Medical Practice:
Address:
Postcode:
Telephone. No:

		Please provide details if answered yes to any questions:
Does he/she have any known medical condition?	Yes / No	
Does this require attention in school ie diet/medication?	Yes/No	
Is your child on regular medicine/treatment?	Yes/No	
Has he/she ever been admitted to hospital?	Yes/No	
Does he/she suffer with Asthma?	Yes/No	
Does he/she have any known allergies? ie egg, nut, fish etc	Yes/No	
Does he/she have a known visual problem?	Yes/No	
Does he/she wear glasses?	Yes/No	
Does he/she have hearing problems?	Yes/No	
Does he/she have a history of intermittent ear problems?	Yes/No	
Does he/she have any known speech or language problems?	Yes/No	
Is he/she left handed, right handed, undecided?	Left handed, right handed or undecided (please delete as appropriate)*	
Has your child had their Measles, Mumps and Rubella (MMR) vaccination? If yes, please give date:	Yes/no	Date of MMR:

Dietary Needs

Egg Allergy	Yes/No	If Yes please given further details
Gluten Allergy	Yes/No	
Milk Allergy	Yes/No	
Nut Allergy	Yes/No	
Seafood Allergy	Yes/No	
Shellfish Allergy	Yes/No	
Halal Only	Yes/No	
Kosher Foods Only	Yes/No	
No Beef	Yes/No	
No Pork	Yes/No	
No Dairy Produce	Yes/No	
Pescatarian	Yes/No	
Vegan	Yes/No	
Vegetarian	Yes/No	
Other Dietary Needs:		

Is there any other information about your child that you would like to have recorded? E.g. religious affiliations, dietary requirements, etc.

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The School are given additional money to support your child for the following:

Is your child adopted, fostered or looked after? Yes/No If yes – please give details:

Does either parent work for the armed forces? Yes/No If yes, please give details:

Please tick if you are in receipt of any benefits and believe your child is eligible for Pupil Premium Funding: ☐

Any other information you feel the school need to know about your child:

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Parent/Guardian Signature: **Date:**