



# CHADSMOOR COMMUNITY INFANT & NURSERY SCHOOL

## ADMISSION FORM

<b>Surname of child:</b>					
<b>Forenames:</b>					
<b>Date of Birth:</b>		<b>Sex:</b>			
<b>Home Address:</b>					
<b>Postcode:</b>					
<b>Home Telephone:</b>					
<b>Parent/Guardian <i>residing with child</i>:</b>					
<b>1.</b>	<b>Name: (Mrs/Mr/Miss)</b>		<b>Work Address and Telephone:</b>		
	<b>Mobile No:</b>				
	<b>Relationship to the child:</b>				
<b>2.</b>	<b>Name: (Mrs/Mr/Miss)</b>		<b>Work Address and Telephone:</b>		
	<b>Mobile No:</b>				
	<b>Relationship to the child:</b>				
<b>Names of older brothers/sisters:</b>					
<b>Ethnic Group:</b>		<b>Religion:</b>			
<b>Language spoken at home:</b>					
<b>Dinner Arrangements <i>(please tick your expected main choice)</i> :</b>					
<input type="checkbox"/> School Dinner - <i>Paid</i>	<input type="checkbox"/> School Dinner – <i>Free</i> <i>(Income based claim)</i>		<input type="checkbox"/> Sandwiches		
<b>Travel Arrangements:</b>					
<input type="checkbox"/> Walk	<input type="checkbox"/> Bus	<input type="checkbox"/> Car/Van	<input type="checkbox"/> School Bus		
<input type="checkbox"/> Taxi	<input type="checkbox"/> Train	<input type="checkbox"/> Car share <i>with other child/children</i>			
<b>For Office Use</b>	<b>Birth Certificate seen</b>		<b>Initial</b>		
	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;">YES</td> <td style="width: 50%; text-align: center;">NO</td> </tr> </table>		YES	NO	
YES	NO				

<b>Previous Educational Experiences:</b>		
<b>Playgroup:</b>	<b>From:</b>	<b>To:</b>
<b>Nursery:</b>	<b>From:</b>	<b>To:</b>
<b>School:</b>	<b>From:</b>	<b>To:</b>

**MEDICAL INFORMATION**

<b>Doctor (Name, Address &amp; Tel):</b>			
<b>Is your child left or right handed?</b>			
<b>Does your child:</b>	<b>Yes</b>	<b>No</b>	<b>If yes, please give details</b>
Suffer from epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	.....
Suffer from diabetes	<input type="checkbox"/>	<input type="checkbox"/>	.....
Suffer from asthma	<input type="checkbox"/>	<input type="checkbox"/>	.....
Suffer from eczema	<input type="checkbox"/>	<input type="checkbox"/>	.....
Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>	.....
Have any allergies	<input type="checkbox"/>	<input type="checkbox"/>	.....
Have any special dietary needs	<input type="checkbox"/>	<input type="checkbox"/>	.....
Have a speech problem	<input type="checkbox"/>	<input type="checkbox"/>	.....
Attend speech therapy	<input type="checkbox"/>	<input type="checkbox"/>	.....
Have any other physical problems	<input type="checkbox"/>	<input type="checkbox"/>	.....
<b>Has your child had any infectious diseases?</b>			
Measles	Mumps	German Measles	Chicken Pox
Scarlet Fever	Other		
<b>Has your child had injections for</b>			
Diphtheria	Tetanus	Whooping Cough	Polio
Measles	Meningitis	Other	
<b>Please provide any other relevant information:</b>			

## Additional Emergency Contacts

Please list below any other daytime emergency contacts (in priority order) other than parents listed on the Admission Form.

For example, any relative, neighbour, etc, known and trusted by you and your child.

<b>3.</b>	<b>Title: (Mr/Mrs/Miss)</b>	<b>4.</b>	<b>Title: (Mr/Mrs/Miss)</b>
<b>Surname:</b>		<b>Surname:</b>	
<b>Forname:</b>		<b>Forname:</b>	
<b>Address (Work/Home):</b>		<b>Address (Work/Home):</b>	
<b>Postcode:</b>		<b>Postcode:</b>	
<b>Tel:</b>		<b>Tel:</b>	
<b>Mobile:</b>		<b>Mobile:</b>	
<i>Relationship to child:</i>		<i>Relationship to child:</i>	
<b>5.</b>	<b>Title: (Mr/Mrs/Miss)</b>	<b>6.</b>	<b>Title: (Mr/Mrs/Miss)</b>
<b>Surname:</b>		<b>Surname:</b>	
<b>Forname:</b>		<b>Forname:</b>	
<b>Address (Work/Home):</b>		<b>Address (Work/Home):</b>	
<b>Postcode:</b>		<b>Postcode:</b>	
<b>Tel:</b>		<b>Tel:</b>	
<b>Mobile:</b>		<b>Mobile:</b>	
<i>Relationship to child:</i>		<i>Relationship to child:</i>	