



COALWAY COMMUNITY INFANT SCHOOL **ADMISSION FORM**

SURNAME: _____ FORENAME: _____ OTHER NAMES: _____

DATE OF BIRTH: ____/____/____ COUNTRY OF BIRTH: _____ PUPIL NATIONALITY: _____

POSITION IN FAMILY: _____ SEX (M/F): _____
(e.g. eldest of 3 children)

HOME ADDRESS: _____

(Town) _____

(County) _____ Post Code _____

HOME TELEPHONE: _____ MOBILE PHONE: _____

E-mail ADDRESS: _____

PARENT/GUARDIAN(S): _____ (e.g. Mr. & Mrs. Smith)

DAYTIME EMERGENCY CONTACTS:

1st Contact:

2nd Contact:

NAME: _____

RELATION: _____

TELEPHONE NO: _____

MOBILE NO: _____

PLACE OF CONTACT: _____

3rd Contact:

4th Contact:

NAME: _____

RELATION: _____

TELEPHONE NO: _____

MOBILE NO: _____

PLACE OF CONTACT: _____

N.B. Should an accident occur during the school day and we are unable to contact a child's parent then, unless we are expressly instructed in writing to the contrary, the Head Teacher will take appropriate action.

USUAL TRAVEL TO SCHOOL (please tick **one**) Walk Public Bus Private Car/Van Taxi Car share

ETHNIC/CULTURAL:

FIRST LANGUAGE OF CHILD: _____ FIRST LANGUAGE OF PARENT: _____

LANGUAGE SPOKEN AT HOME: _____ RELIGION: _____ (reply optional)

SCHOOL HISTORY:

PREVIOUS SCHOOL/NURSERY: _____

ADDRESS: _____

Please specify - FULL TIME PART TIME HOW MANY TERMS OF PRE-SCHOOL EDUCATION _____

SCHOOL MEALS:

I have completed the school meal registration form (please tick)

USUAL DINNER ARRANGEMENTS: (please tick **one**) School meal Free meal Packed Lunch

DIETARY NEEDS: (please tick any that apply to your child)

- | | | |
|---|---|--|
| <input type="checkbox"/> Artificial colouring allergy | <input type="checkbox"/> Kosher foods only | <input type="checkbox"/> No pork |
| <input type="checkbox"/> Gluten free | <input type="checkbox"/> No dairy produce | <input type="checkbox"/> Seafood allergy |
| <input type="checkbox"/> Halal | <input type="checkbox"/> No nuts of any type/quantity | <input type="checkbox"/> Vegetarian |

MEDICAL INFORMATION:

DOCTOR/MEDICAL PRACTICE: _____

ADDRESS: _____

TELEPHONE: _____

MEDICAL INFORMATION: _____

(e.g. impaired hearing, wears glasses, unclear speech, hospitalisation, premature birth, allergies, fears, referrals etc.)

MEDICAL CONDITIONS:

(please tick any that apply to your child)

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> None applicable |

MEDICAL SUPPORT:

(please tick any that apply to your child)

- | |
|---|
| <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Physiotherapy |
| <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> None applicable |
| <input type="checkbox"/> Other |

SPECIAL EDUCATIONAL NEEDS/DISABILITY:

(please tick any that apply to your child)

- My child has special educational needs
- My child has a disability

Please give full details below: _____

This form was completed by: _____

Signed _____ **Date** _____

Relationship to child _____