



St. John's CE Middle School



Breakfast and After School Club Registration Form

Child's name.....Date of Birth.....

Address.....

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Postcode.....Home Telephone

Mobile Number.....Work Number.....

E:mail address.....

1. Address and telephone number where parent/guardian or other person
With parental responsibility can be contacted

<u>Daytime</u>	<u>Evening</u>

2. Does your child suffer from any allergies? If so give details

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3. Has your child had a tetanus injection in the last 5 years? If so date
if known

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4. Is your child taking any medication? If so please give details

5. Please give name, address and telephone number of your family doctor

6. Does your child have any dietary requirements? *Yes/No
If yes please give details

7. Is there any activity in which your child is unable *Yes/No
to participate?
If yes please give details

Is there any other information we need to be aware of?

If it becomes necessary for my child to receive medical treatment and I cannot be contacted by telephone or by any other means I hereby give my general consent for any necessary treatment and authorise the leader in charge to sign any documentation required by the hospital authorities

Signature of Parent/GuardianDate.....