**LITTLE SHINING LIGHTS**

CHILD REGISTRATION FORM

This is a confidential document, and must be returned prior to your child starting.

Child’s Details

Full name of child …………………………………………………………… Date of birth ………………………

Child known as ………………………………………. Gender…………………………………………………………

Parent Contact Details ………………………………………………………

Parents with whom the child lives …………………………………………………………

Name of Parent 1 …………………………………………………………………………

Does this parent have parental responsibility? Yes/ No

Name of Parent 2 …………………………………………………………………………

Does this parent have parental responsibility? Yes/ No

Home Address……………………………………………………………………………………………………………….

Postcode ………………………………. Home telephone……………………………………

Mobile (parent 1) ……………………………………Work number (parent 1) …………………………………….

Home number (parent 2) …………………………………Mobile number (parent 2) ………………………… Work number (parent 2) ………………………………

Email address …………………………………………………….

Parents with whom the child doesn’t live

Name of Parent…………………………………………………………………….

Does this parent have parental responsibility? Yes/ No ………………………………………………………………

Does this person have legal access to the child? Yes/ No ……………………………………………………………

Home Address……………………………………………………………………………………………………………………

Post Code………………………………………………………………

Telephone………………………………………………Mobile phone………………………………………………….

Email address ………………………………………………………………….

Any person to whom the child should not be handed over to …………………….……………………………………………………………………………………………………………

Additional persons authorised to pick up the child (must be over 16 years of age)

Name …………………………………………………………… Relationship to child …………………………………...

Telephone Mobile ……………………………………

Name…………………………………………………………… Relationship to child ……………………………………

Telephone Mobile…………………………………….

Password to be used on collection…………………………………….

Personal Details of the child ………………………………………………………

What is the main religion of your family?...........................................................................................

Are there any festivals or special occasions celebrated in your culture that you would like acknowledged and celebrated in the setting?........................................................................................................................................

What language(s) are spoken at home?...............................................................................................

Medical Information:

Name of Doctor…………………………………………………………………………….

Name of GP ………………………………………………

Address of GP …………………………………………………………………………………………………………………….

Telephone………………………………………………….

Name of Health Visitor……………………………………………………….

Details of any health problems………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………

Are your child’s immunisations up to date? Yes/ No If no, please specify ……………………………………….

Do you know of any allergies your child may have? …………………………………………………………………….

Does your child have any specific dietary requirements?..........................................................

………………………………………………………………………………………………………………………………………………

Additional needs

Does your child have any additional needs or disabilities? Yes/ No

 If yes, please provide details

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Are any of the following in place for the child? Early Years Action Yes/ No

Early Years Action Plus Yes/ No

Statement of Special Education needs Yes/ No

**Details of other childcare settings**

Is your child transferring to us from another childcare setting/ child minder? Yes/ No

If yes, please provide the following details:

Name of provider/ child minder……………………………………………………………………………………

Name of key worker ……………………………………………………………………

Address……………………………………………………………………………………………………… Postcode……………………. Telephone ………………………………………………………

Are you happy for us to contact the setting for information on your child to ensure continuity of care? Yes/ No

Does your child currently attend another setting alongside Little Shining Lights? Yes/ No

If yes, please provide the following details:

Name of provider/ child minder ……………………………………………………………………………………………….

Name of key worker………………………………………………………………………………

Address …………………………………………………………… Postcode………………………. Telephone……………………………………….

Are you happy for us to contact the setting and share information to ensure continuity of care? Yes/ No

Are you happy for us to send copies of all progress reports to the setting? Yes/ No

Details of other professionals involved with the child.

Name 1…………………………………………………………………….

Role …………………………………………………………………………

Agency ………………………………………………………………. Telephone…………………………………………

Name 1 ………………………………………………………Role ………………………………………………………….

Agency……………………………………………………………Telephone ………………………………………

Does your family have a social worker for any reason? Yes/ No

Name based at ……………………………………………………………………………….

What is the reason for involvement of the social care department with your family?

……………………………………………………………………………………………………………………………………………

 **I give my authority for the staff of Little Shining Lights to: -**

a) Take responsibility for my child during their sessions.

b) Take my child on outings or visits within the community a long day trip subject to notification that a trip is taking place.

c) Take photographs of my child whilst at the setting for their Learning Journals.

d) Make observations of my child for the purpose of assessment and training courses.

e) Pass assessment records onto school unless requested in writing not to do so.

Signed by:

Parent 1

Print name…………………………………………………………………………

Parent 2

Print name………………………………………………………………………….

Date…………………………………………………………………………