

School  
Photograph  
Will Be  
Inserted Here



**PRE – AND POST SCHOOL CARE SCHEME**  
**REGISTRATION AND CONTACT FORM**

Name of Child .....

Preferred Name.....

Date of Birth ..... Gender  Male  Female

Home Address:  
.....  
.....  
.....

Home Telephone: .....

Mother's contact numbers:  
Home: ..... Mobile: ..... Work: .....  
Email: .....

Father's contact numbers:  
Home: ..... Mobile: ..... Work: .....  
Email: .....

Contact in an emergency .....

Names & telephone numbers of persons who may collect your child .....

.....  
.....

Religion .....

Other relevant Information e.g dietary / specific requirements.....  
.....

Sessions required: (please tick as required)

Pre School:	Monday	Tuesday	Wednesday	Thursday	Friday
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post School:	Monday	Tuesday	Wednesday	Thursday	Friday
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3.30-5.00pm	3.30-5.00pm	3.30 -5.00pm	3.30-5.00pm	3.30-5.00pm
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3.30-6.00pm	3.30-6.00pm	3.30-6.00pm	3.30-6.00pm	3.30-6.00pm

**Please Complete Details Overleaf.**

**PRE – AND POST SCHOOL CARE SCHEME**

**REGISTRATION AND CONTACT FORM**



**THE KING'S SCHOOL**  
C H E S T E R

We also offer swim sessions on Mondays, Thursdays and Fridays at no extra cost. Please indicate if you consent to your child participating.

Swim  YES  NO

My child's swimming ability is.. ..

I understand my child will not be directly supervised at all times, but that appropriate supervision and training where necessary will be provided for all organised activities.

I agree to my child receiving emergency treatment, including anaesthetic, surgery and blood transfusion, as considered necessary by the medical authorities present. In the event of an emergency I understand every effort will be made to contact me / us. Signature of parent .....

**MEDICAL DETAILS**

Child's Doctor .....

Doctors Address .....

Doctors Telephone Number .....

Allergies/Medication .....

Specific requirements or any information you feel we need to know.....

Immunisations (are all your child's vaccinations up to date?)  Y  N

Particularly Diptheria/Tetanus and Polio (booster) (3-5 years) Date given: .....

I agree to give my consent to the following

- 1. Any emergency treatment necessary during the running of the scheme.
- 2. If my child requires urgent medical attention, scheme staff may contact my child's doctor or hospital before contacting me.

I confirm that I have read a copy of the scheme's policies and procedures and agree to abide by the terms and the conditions.

Signed ..... (Parent / Guardian) Date .....

Office use only    Birthday     Confirmation     Mailing List