



APPLICATION FORM: PREPARATORY DEPARTMENT (8-11 years)

CHILD'S DETAILS			
SURNAME:			
FORENAME(S):			
MIDDLE NAME(S):			
PREFERRED NAME:			
DATE OF BIRTH*		FEMALE <input type="checkbox"/>	MALE <input type="checkbox"/>

*A copy of your child's birth certificate is required. Please bring in the original for the Registrar to copy.

PROPOSED START DATE:			
Will you use our holiday playschemes?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	

NATIONALITY:	RELIGION:		
FIRST LANGUAGE:			
ANY ADDITIONAL LANGUAGES:			
CURRENT SCHOOL:			
DATE FROM:		DATE TO:	

ANY SIBLINGS: (WITH AGES)	
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How did you hear about us?			
Local knowledge		Press advert	
Website		Sibling already attends	
Recommendation		Other	
If recommendation, please give us the name:			

For office use only	Class:		House:		Birth certificate ref:					
Registrar:		Bursar:		Form tutor:		SIMS:		Adm No:		Last updated: 31 January 2019



APPLICATION FORM: PREPARATORY DEPARTMENT (8-11 years)

PARENT(S)/GUARDIAN(S) DETAILS			
PARENT/GUARDIAN 1			
TITLE	FORENAME	SURNAME	
RELATIONSHIP TO CHILD: (if relevant, please indicate which parent has custody)			
OCCUPATION		PLACE OF WORK	
POSTAL ADDRESS			
		POSTCODE:	
Is this your child's primary residence?			YES <input type="checkbox"/> NO <input type="checkbox"/>
HOME NUMBER:		MOBILE NUMBER:	
WORK NUMBER:		OTHER NUMBER:	
PREFERRED EMAIL ADDRESS TO RECEIVE SCHOOL INFORMATION:			
PARENT/GUARDIAN 2			
TITLE	FORENAME	SURNAME	
RELATIONSHIP TO CHILD: (if relevant, please indicate which parent has custody)			
OCCUPATION		PLACE OF WORK	
POSTAL ADDRESS		<i>(if same as above please leave blank)</i>	
		POSTCODE:	
Is this your child's primary residence?			YES <input type="checkbox"/> NO <input type="checkbox"/>
HOME NUMBER:		MOBILE NUMBER:	
WORK NUMBER:		OTHER NUMBER:	
PREFERRED EMAIL ADDRESS TO RECEIVE SCHOOL INFORMATION:			



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EMERGENCY CONTACT DETAILS

Please provide at least one additional contact number for someone we can contact in the event of an emergency where we cannot get hold of a parent or guardian.

EMERGENCY CONTACT 1 DETAILS

TITLE	FORENAME	SURNAME

TELEPHONE NUMBER(S):

RELATIONSHIP TO CHILD:

EMERGENCY CONTACT 2 DETAILS

TITLE	FORENAME	SURNAME

TELEPHONE NUMBER(S):

RELATIONSHIP TO CHILD:

TERMS AND CONDITIONS

I/we agree to the terms and conditions of the school prospectus and supplementary information.

I/we realise that there is no refund given for absence and that for children over 2½ years, one full term's notice in writing is required, to be addressed to the Headmaster, to expire at the end of a full term. Failure to provide the required notice period will result in a term's fees being payable in lieu of notice.

I/we have paid a non-refundable registration fee of £100.00. Payment may be made by card, in cash or online via BACS. Our bank details are available upon request.

I/we give permission for the Headmaster, or his representative, to act in loco parentis in a medical emergency.

SIGNATURE:
(Parent/Guardian 1):

DATE:

SIGNATURE:
(Parent/Guardian 2):

DATE:

<i>For office use only</i>	<i>Reg fee paid:</i>	£	<i>Card:</i>	<i>BACS:</i>	<i>Cash:</i>	<i>Payment taken by (initials):</i>	<i>Date:</i>	/	/
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CONFIDENTIAL MEDICAL INFORMATION FORM

CHILD'S DETAILS			
SURNAME:		FORENAME:	
CLASS:		DATE OF BIRTH:	MALE/FEMALE

MEDICAL CONDITIONS

Please indicate below any medical conditions and/or allergies which apply to your child, including details of any treatment or medication

Asthma	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Allergies (eg. dairy, gluten, eggs, nuts etc)	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Coeliac's Disease	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Diabetes - Type 1	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Eczema	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Epilepsy	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Eye conditions (eg. wears contact lenses)	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Hearing conditions	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Heart conditions	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Unknown allergies	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Other	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

If you have ticked 'yes' to any of the above, please give further details below:

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Please give details of any medication/treatment needed (eg. inhaler, EpiPen):

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For office use only	SIMS updated:		Initials:		Date:		template updated: 31 January 2019
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CONFIDENTIAL MEDICAL INFORMATION FORM

DIETARY RESTRICTIONS

*Please note: WE HAVE A STRICT **NO NUTS, SESAME SEEDS, KIWI OR COCONUT** POLICY IN PLACE AT MKPS*

Please tick below to indicate any dietary restrictions which apply to your child, including if possible the reason (eg. dietary, religious)

Meat			
No beef	<input type="checkbox"/>	No chicken	<input type="checkbox"/>
		No lamb	<input type="checkbox"/>
			No pork/ham/bacon <input type="checkbox"/>

Reason:

Fish			
No white fish	<input type="checkbox"/>	No salmon	<input type="checkbox"/>
		No tuna	<input type="checkbox"/>
			No shellfish <input type="checkbox"/>

Reason:

Dairy produce			
No butter	<input type="checkbox"/>	No cheese	<input type="checkbox"/>
		No cold milk	<input type="checkbox"/>
			No milk in cooked goods <input type="checkbox"/>
No yoghurt	<input type="checkbox"/>	No cow's milk	<input type="checkbox"/>

Reason:

Gluten/cereals			
No wheat	<input type="checkbox"/>	No oats	<input type="checkbox"/>
		No barley	<input type="checkbox"/>
			No soya <input type="checkbox"/>

Reason:

Miscellaneous	
No eggs - unless cooked into foods	<input type="checkbox"/>
No eggs - at all	<input type="checkbox"/>
No gelatine	<input type="checkbox"/>
Vegan	<input type="checkbox"/>
Vegetarian - can eat seafood	<input type="checkbox"/>
Vegetarian - no seafood	<input type="checkbox"/>
Other (please give details below)	<input type="checkbox"/>

If you have ticked 'yes' to any of the above, please give further details below:



CONFIDENTIAL MEDICAL INFORMATION FORM

MEDICAL INFORMATION

Please give details below of the GP your child is registered with:

GP/Health Centre name:

Address:

Tel:

CHILDHOOD VACCINATIONS

Please indicate below by ticking and completing the dates as appropriate:

Vaccine:	Vaccination date(s):		
6-in-1 or equivalent (Diphtheria, tetanus, polio, whooping cough, Haemophilus influenzae type B & Hep B)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
PCV	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Rotavirus	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
Men B	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Hib/Men C	<input type="checkbox"/>		
MMR	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
4-in-1 Pre-school booster (Diphtheria, tetanus, whooping cough, & polio)	<input type="checkbox"/>		
2 year check	<input type="checkbox"/>	Please provide a copy of the report	

PARENTAL CONSENT

It is important that all children with medical conditions are supported in school and some children may need medical care or attention to keep them well and comfortable during the school day. Please help us by filling in the above form as completely as possible so that we are able to assess and regularly review your child's health and dietary needs and, where appropriate, discuss in further detail with Matron to ensure any medical needs are met appropriately within school.

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school to discuss this information with the School's Matron or other health professionals who are involved in my child's care.

Parent's/Guardian's details:

Name/s:		
Signature/s:		
Date:		