



ADMISSION AGREEMENT

Preschool & Day Nursery

Password

Child's First Name

Surname

Date of Birth

DD	MM	YY
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Age

Home Address

.....

.....

Home Telephone No.

Start Date

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Mothers First Name:

Surname

Fathers First Name

Surname

Mothers Work

.....

Work Telephone No.

Mobile

Fathers Work

.....

Work Telephone No.

Mobile

For Office Use Only

Start Date

DD	MM	YY
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Room

Date Deposit Paid

DD	MM	YY
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Deposit Amount

Nursery Cam activated

DD	MM	YY
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Gingerbread House, 137 Liverpool Road, Crosby, Liverpool, L23 5TF. Tele: 0870-220-2436

E.mail: info@gingerbread-house.co.uk Web Site: www.gingerbreadpreschools.com

Emergency Contacts

First Contact

First Name Surname

Relationship to Child Mobile

Home Telephone Work Tele

Adress

Second Contact

First Name Surname

Relationship to Child Mobile

Home Telephone Work Tele

Adress

Health Details

Doctor's Name Tele No:

Surgery Address

Health Visitor's Name Tele No:

Does your Child have any special needs? Yes No

Is your child on regular medication? Yes No

Does your child have any special dietary requirements? Yes No

Do you have any special words that you use for going to the potty/toilet or other needs? Yes No

Does your child have any known allergies? Yes No

If you have answered yes to any of the above please supply details below

Health Details Continued

Vaccina Please tick which vaccinations your child has had

Polio	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date	<input type="checkbox"/>
Measles/M	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date	<input type="checkbox"/>
Diphtheria/M	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date	<input type="checkbox"/>
Meningitis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date	<input type="checkbox"/>
HIB	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date	<input type="checkbox"/>

Present Health

Does your child suffer from/have/need

Regular me	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Eyesight Pr	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Hearing Pr	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Asthma/Re	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Hay Fever	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Does your child require regular me	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If you have answered yes to any of the above please give details.

Is there any other medical information you feel we should know about to provide care for your child?