CHELLASTON JUNIOR AND INFANT SCHOOLS
Maple Drive
Chellaston
DERBY DE73 6PZ
Telephone 07910 225663

Manager: Mrs Sarah Woolley
S.woolley@chellastonjuniors.org

ADMISSION FORM

Childs details

Full Name	Male/Female	D.O.B
Address		
Home phone number		
Name and Adress of Doctors surgery Telephone Number		
Nationality	Religion	
Ethnicity		
EMAIL address		

Parents/Guardians Details

Name: Relationship:	Mobile Number: Daytime Number:
Name: Relationship:	Mobile Number: Daytime Number:
Other Emergency Contact Details:	
Name: Relationship:	Mobile Number: Daytime Number:
Name: Relationship:	Mobile Number: Daytime Number:

Names of Person/s authorized to collect your child.

Name……………………………………………….Relationship……………………………………………….

Name………………………………………………. Relationship……………………………………………….

Name………………………………………………. Relationship……………………………………………….

MEDICAL INFORMATION

A) If your child has any conditions, which require medical threatment please give details below:

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B) Does your child suffer from allergies? Please give details below:

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C) Please state any special dietary requirements for your child:

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D) Is there any further information, which you feel we should know about your child?

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I understand that if my child is injured whilst at "The Zone" then He/She will receive appropriate medical treatment and attention.
Furthermore I hearby authorise "The Zone"/School staff, to consent to any medical treatment which a qualified medical practitioner deems necessary for my child.
NB: This will come into force once all emergency contact numbers have been exhausted.

Signature……………………………………………………………Date…………………………………