



Registration Form

Stay, Play and Learn drop-in Crèche

* Children cannot attend the crèche without prior completion of this form

First Steps First

Hall 2 Marlow Air Scouts

01628 483111

Email address: susan@firststepsfirst.co.uk

Child's details

Child's first name(s) _____ Surname _____

Name known as _____

Child's full address _____

Gender _____ Date of birth _____

Family details

Name of parent(s)/carer(s) with whom the child lives: _____

Contact details 1 (including emergency information):

Parent/carers full name _____

Relationship to child _____

Daytime/work telephone _____ Mobile _____

Home telephone _____ Email _____

Home address _____

Work address

Does this parent have parental responsibility for the child? Yes ☐ No ☐

Contact details 2 (including emergency information):

Parent/carer full name

Relationship to child

Daytime/work telephone

Mobile

Home telephone

Email

Home address

Work address

Does this parent have parental responsibility for the child? Yes ☐ No ☐

Contact details 3 (including emergency information):

Parent/carer full name

Relationship to child

Daytime/work telephone

Mobile

Home telephone

Email

Home address

Work address

Does this parent have parental responsibility for the child? Yes ☐ No ☐

Other person(s) with legal contact *To be completed where those persons with parental responsibility are separated and an S8 Order is in place.*

Name

Address

Contact telephone numbers

Relationship to child

What are the contact arrangements that [we/I] need to be aware of?

Emergency contact details if parents are not available *Emergency contacts must be local.*

Contact 1 - Name

Relationship to child

Address _____
Daytime/work telephone _____
Home telephone _____ Mobile _____

Contact 2 - Name _____
Relationship to child _____
Address _____
Daytime/work telephone _____
Home telephone _____ Mobile _____

Persons other than parent(s) authorised to collect the child *Must be over 16 years of age. Please note that if the authorised person is not the person indicated on the daily signing in/out sheet we will check before releasing the child.*

Person 1 – Name _____
Relationship to child _____
Address _____
Daytime/work telephone _____
Home telephone _____ Mobile _____

Person 2 - Name _____
Relationship to child _____
Address _____
Daytime/work telephone _____
Home telephone _____ Mobile _____

Person 3 - Name _____
Relationship to child _____
Address _____
Daytime/work telephone _____
Home telephone _____ Mobile _____

Password for the collection of child by authorised persons _____ To be arranged on the day by the setting and parent _____

About your child

The following information will tell us a little more about your child. As your child settles with us, we will establish their starting points through observation and further conversation with you.

Does your child have previous experience of attending a child care setting? If so, please specify:

Health and development

Has your child received the following immunisations? *Please confirm and provide date of immunisations given.*

| | | | | |
|--|--|------------------------------|-----------------------------|-------|
| Two months old | 5-in-1 (DTaP/IPV/Hib) vaccine - diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib). | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date: |
| | Pneumococcal (PCV) vaccine. | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date: |
| | Rotavirus vaccine. | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date: |
| Three months old | 5-in-1 (DTaP/IPV/Hib) vaccine, second dose - diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib). | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date: |
| | Meningitis C vaccine. | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date: |
| | Rotavirus, second dose. | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date: |
| Four months old | 5-in-1 (DTaP/IPV/Hib) vaccine, third dose - diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib). | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date: |
| | Pneumococcal (PCV) vaccine, second dose. | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date: |
| Between 12 and 13 months old | Hib/Men C booster - Haemophilus influenza type b (Hib), forth dose and meningitis C, second dose. | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date: |
| | MMR vaccine – mumps, measles and rubella. | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date: |
| | Pneumococcal (PCV) vaccine, third dose. | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date: |
| Two to three years | Flu vaccine | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date: |
| Three years and four months or soon after | MMR vaccine, second dose – mumps, measles and rubella. | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date: |
| | 4-in-1 (DTaP/IPV) pre-school booster - diphtheria, tetanus, pertussis (whooping cough) and polio. | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date: |

Does your child have any on-going medical conditions? If so, please specify, as ratios must be taken into consideration

If yes, please specify which external agencies are involved e.g. Paediatrician, Consultant, Dietician, Speech and Language Therapist, etc:

Does your child require a health care plan? Yes ☐ No ☐

Is your child known to have any allergies or food intolerances? If so, please specify:

A risk assessment will be completed and kept on the child's file for any known allergies or food intolerance as mentioned above.

What are your child's dietary requirements? Please specify:

If your child is aged three years or over, does he or she have difficulty with any of the following:

| | | | | |
|--|-----|--------------------------|----|--------------------------|
| Speaking and communicating | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Listening and attending | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Understanding simple instructions | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Eating and drinking | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Sitting and sharing a book | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Walking and climbing | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Rolling a ball | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Holding a crayon | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Socialising with adults and other children | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Using the toilet | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Putting on their shoes and socks | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

Any other concerns:

Does your child have any special needs or disabilities (SEND)? If so, please specify as ratios must be taken into consideration.

Are any of the following in place for the child?

SEN action plan

Education, Health and Care Plan

What special support will he/she require in [our/my] setting?

Two year old progress check – children aged 24 – 36 months

If your child is aged between 24-36 months, has a two year old progress check already been completed for your child? Yes ☐ No ☐

Setting completing check _____ Date completed _____

As per the requirements of the Early Years Foundation Stage we will complete a progress check on your child between the ages of 24-36 months. We will ask you to be involved in completing the check and will discuss it with you.

Cultural background

How would you describe your child's ethnicity or cultural background?

What is the main religion in your family (if applicable)? _____

Are there any festivals or special occasions celebrated in your culture that your child will be taking part in and that you would like to see acknowledged and celebrated while he/she is in [our/my] setting?

What language(s) is/are spoken at home? _____

If English is not the main language spoken at home, will this be your child's first experience of being in an English-speaking environment? Yes ☐ No ☐

Does your child speak any other language? Yes ☐ No ☐

Details of professionals involved with your child

GP

Name _____ Telephone _____
Address _____

Health Visitor (if applicable)

Name _____ Telephone _____
Address _____

Social Care Worker (if applicable)

Name _____ Telephone _____
Address _____

What is the reason for the involvement of the social care department with your family? *NB If the child has a child protection plan, make a note here, but do not include details. [We/I] will ensure these details are obtained from the social care worker named above and keep these securely in the child's file.*

Dentist (if applicable)

Name _____ Telephone _____
Address _____

Any other professional who has regular contact with the child

Name 1 _____ Role _____
Agency _____ Telephone _____
Address _____

Name 2 _____ Role _____
Agency _____ Telephone _____
Address _____

Name 3

Role

Agency

Telephone

Address

General parental permissions

Emergency treatment declaration

In the event of an accident or emergency involving my child I understand that every effort will be made to contact me immediately. Emergency services will be called as necessary and I understand my child may be taken to hospital accompanied by the manager or authorised deputy for emergency treatment and that health professionals are responsible for any decisions on medical treatment in my absence.

Signed _____

Date _____

Printed name _____

For inhalers/auto-injectors (e.g. Epipens) only

I give permission for a named member of staff who has been appropriately trained to administer the inhaler/
Epipen or Anapen (supplied _____ (name of child).
by me) to _____

The named staff are:

Signed

Date

Printed name

Suncream

I give permission for staff to administer hypoallergenic sun cream (supplied by me) when necessary

Signed _____

Date _____

Printed name

Policies and procedures

I have been provided with details of First Steps First early years prospectus for parents, and understand that I

The Sharing Policy: I understand that there may be circumstances where information is shared with other professionals or agencies without my consent.

Signed _____

Date _____

Printed name

Please sign below to indicate that the information given on this form is accurate and correct, and that you will if you require the services of the crèche notify us of any changes as they arise.

Signed _____ Date _____

Name of manager Susan Campbell-Baker _____

Signed _____ Date _____

Equalities monitoring form

Ethnicity - Gathered for monitoring purposes only. Parents are not obliged to complete this data.

| | | | |
|--------------------|--------------------------|---------------------------|--------------------------|
| White British | <input type="checkbox"/> | Pakistani | <input type="checkbox"/> |
| White Irish | <input type="checkbox"/> | Indian | <input type="checkbox"/> |
| White other | <input type="checkbox"/> | Asian other | <input type="checkbox"/> |
| Black British | <input type="checkbox"/> | Chinese | <input type="checkbox"/> |
| Black African | <input type="checkbox"/> | Chinese other | <input type="checkbox"/> |
| Black Caribbean | <input type="checkbox"/> | White and Black Caribbean | <input type="checkbox"/> |
| Black Other | <input type="checkbox"/> | White and Black African | <input type="checkbox"/> |
| Bangladeshi | <input type="checkbox"/> | White and Black Asian | <input type="checkbox"/> |
| Other please state | _____ | | |

A child's learning difficulties and disabilities status should be recorded according to the following categories:

No special educational need ☐

SEN action plan ☐

Education, Health and Care Plan ☐

Providers should refer to the SEND Code of Practice for the Early Years (2014) for an explanation of the terms above.



Stay, Play and Learn drop-in Crèche

(Please tick and write number of hours – minimum of 2hours, Maximum of 4 hours per day:

Monday **Tuesday** **Wednesday** **Thursday** **Friday**

Morning Session 8:30am-11:30pm (3 hours)

Days
Hours

| | | | | |
|--|--|--|--|--|
| | | | | |
| | | | | |

Lunch 11:30am-12:30pm (1 hour)

Days
Hours

| | | | | |
|--|--|--|--|--|
| | | | | |
| | | | | |

Afternoon Sessions 12:30 pm-3:30pm
(3hours)

Days
Hours

| | | | | |
|--|--|--|--|--|
| | | | | |
| | | | | |