

Forms are in compliance with legislation Scottish Statutory Instruments. All details are confidential and will not be divulged to any 3rd party.

**Child Application Form.** Please fill in all fields, if not applicable please state N/A

Breakfast Club / After School Care /Lunch Time Pick Up

Start date: / /

Child’s Name: D.O.B. Class: \_\_

Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Postcode: Home telephone:

Email (correspondence, updates, newsletters):

Mother’s name (or main carer):

Work Address:

Work Telephone: Mobile:

Father’s Name (or second carer):

Work Address:

Work telephone: Mobile:

Additional contact name (this needs to be a person your child knows):

Address:

Telephone: Mobile:

Days Requested (please circle)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Breakfast Club7.30am start | Monday | Tuesday | Wednesday | Thursday | Friday |
| Lunch Time Pick Up | Monday | Tuesday | Wednesday | Thursday | Friday |
| After School3.00pm – 6.00pm | Monday | Tuesday | Wednesday | Thursday | Friday |



Who will be collecting your child? **What is your family password?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- |
| Please fill in names below. (Please Tick Box) |
| Adult’s Name: (Sibling: over 14. Others: over 16) | Single occasion | Whennotified | No notification needed |
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|  |  |  |  |

***I give permission for my child (Please tick):***

Receive emergency first aid and visit dental hospital/ hospital in the case of emergency. YES/NO

To view PG Films YES/NO

Face painting. YES/NO

Apply sunscreen. YES/NO

Supervised use of the internet YES/NO

To view PG Films YES/NO

Nail polish YES/NO

Plasters YES/NO

I/We agree to accept the placement at the facility and accept the conditions of giving one-month’s notice when leaving or one month’s fees in lieu. (Payment by standing order only – term time).

I understand that any absences are to be paid and non transferable.

I understand and agree that fees are non-refundable in the event that the facility is forced to close for any period due to unforeseeable circumstances.

I/We agree to accept a placement at ScotNursing and accept the conditions as set out in the parent Contract.

All information above is correct according and realise that any changes must be updated immediately (failure to advise could breach any placement).

ScotNursing Ltd reserves the right to withdraw a place in terms of the exclusion/ withdrawal policy as set out in the parent contract.

Signed: Date:



Child’s Personal Profile

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| --- |
| Child’s name: Date of Birth:  |
| Physical description of your child (heights, hair and eyes colour): |
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|  |
| **Health & Well Being Details** |
| Please give details of any medical conditions, disorder or disability: |
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|  |
| Please give details of any Allergies, ailments and intolerances/dietary requirements: |
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|  |
| Name and Address of family doctor: |
|  |
|  |
| Surgery telephone no.: |
|  |
| Any other details: |
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| What does your child need physically? |
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|  |
| What does your child need emotionally? |
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|  |
| What raises your child’s anxieties? |
|  |
|  |
| What calms and relaxes your child? |
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|  |
| Does your child use any special words or signals that help them? |
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| Is there any other way we can support your child’s development? |
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| What, if any, other professional is currently supporting your child? |
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| In the interests of continuity of care for your child, if necessary, do you consent to us contacting this professional? YES/NO |



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| **In addition**During Induction your child will be shown around the environment and the ‘routines and rules’ will be explained and discussed with them. In order to fully meet all children’s needs it is important that as much information as possible is gathered about your child. This will sometimes mean contacting your child’s school or class teacher for information regarding the support measures and strategies they have in place for your child. If you do not wish this to happen, please contact the Manager. |
| Parents’ comments: |
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|  |
| Child’s comments: |
|  |
|  |
| Review of this plan will take place in: (Staff to complete with parent when necessary) |
| Weeks: Months: |
| Staff signature: | Date: |
| Parent/Carers’ Signature (Relationship to child): | Date: |
| Manager Signature (If required): | Date: |

The child’s views will always be considered where appropriate.