OUR LADY'S CATHOLIC PRIMARY SCHOOL

WRAPAROUND CARE REGISTRATION FORM

PUPIL	
SURNAME	FORENAME
MIDDLENAME(S)	CHOSEN NAME
DATE OF BIRTH	GENDER FEMALE MALE

CONTACT INFORMATION

Please give details of all persons who have Parental Responsibility and anyone else you wish to be contacted in an emergency. Place them in the order you wish them to be contacted.

PARENT/CARER 1	
SURNAME	FORENAME
TITLE Mr/Miss/Mrs/Ms/Other …….	RELATIONSHIP TO PUPIL
ADDRESS Does the pupil live at this address (Y/N)	
CONTACT PRIORITY NUMBER	MOBILE NUMBER
EMAIL	

PARENT/CARER 2	
SURNAME	FORENAME
TITLE Mr/Miss/Mrs/Ms/Other …….	RELATIONSHIP TO PUPIL
ADDRESS Does the pupil live at this address (Y/N)	
CONTACT PRIORITY NUMBER	MOBILE NUMBER
EMAIL	

EMERGENCY CONTACTS

By listing a contact, you are confirming that you have their full knowledge and permission to act as a point of contact for the school.

MORE EMERGENCY CONTACT		
NAME 3	CONTACT NUMBER	RELATIONSHIP
NAME 4	CONTACT NUMBER	RELATIONSHIP
NAME 5	CONTACT NUMBER	RELATIONSHIP
NAME 6	CONTACT NUMBER	RELATIONSHIP

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COLLECTION ARRANGEMENTS

Please list all adults authorised to collect your child. Children will only be released to authorised adults.

MORE EMERGENCY CONTACT		
NAME 1	CONTACT NUMBER	RELATIONSHIP
NAME 2	CONTACT NUMBER	RELATIONSHIP
NAME 3	CONTACT NUMBER	RELATIONSHIP
NAME 4	CONTACT NUMBER	RELATIONSHIP

MEDICAL INFORMATION

FAMILY DOCTOR	
DOCTOR'S NAME	
PRACTICE ADDRESS	
PHONE NUMBER	

Does your child suffer from any of the following *Please tick appropriate box:*			*Please give details including information on name of any medicines including dosage*
Allergies to any known medication	YES	NO	
Any other allergies, e.g. material, food, plasters	YES	NO	
Asthma or bronchitis	YES	NO	
Diabetes	YES	NO	
Fits, fainting or blackouts	YES	NO	
Severe headaches or migraines	YES	NO	
Heart conditions	YES	NO	
Any other illness or disability	YES	NO	
Does your child receive regular medication or medical treatment	YES	NO	
Travel Sickness	YES	NO	
Does your child have any special needs? *This information will be treated with sensitivity and discretion*	YES	NO	
Is your child receiving medical or surgical treatment of any kind from either their family doctor or hospital?	YES	NO	
Has your child received vaccination against Tetanus in the last 10 years?	YES	NO	

Is there any additional medical, personal or family information that you think the school should be aware of:

ADDITIONAL INFORMATION

Please provide any additional information that will help us care for your child, including:

- cultural or religious requirements
- languages spoken
- any additional needs

SESSION REQUIREMENTS

Please tick required sessions:

Breakfast Club (7:45am - 8:45am)

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

After School Club (Monday - Thursday - 3:20pm - 5:15pm, Friday - 3:20pm - 4:15pm)

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

CONSENTS

Medical Consent

I give permission for staff to administer first aid and seek emergency medical treatment if required. ☐ Yes

Photo Consent

I give permission for my child's photograph to be used within school for display and promotional purposes. ☐ Yes ☐ No

Parental Responsibility

I confirm that I have legal parental responsibility for this child. ☐ Yes

Data Protection

The school collects and stores this information in line with UK GDPR.
Data will only be used to ensure the safety and wellbeing of your child.

Full details can be found in our Privacy Notice on the school website.

DECLARATION

I confirm that the information provided is accurate and up to date.

I understand that it is my responsibility to update the school with any changes to these details using a 'Change of Pupil Details' form available from school reception.

Any information given on this form is held on our management information system until your child leaves this school and is not shared with any third parties.

If your child's circumstances change (e.g. relating to medical conditions/allergies), you must inform the school.

SIGNATURE OF PARENT/CARER *please sign below*	
Signature	Signature
Print Name	Print Name
Date	Date