

# Moorlands C of E Primary Academy

## 2018/2019

After School Club Registration Form								
Surname:	Christian Name(s):	Chosen Name:						
Home address:  Post Code:  Home Telephone Number:	Date of Birth:	Gender:  Male / Female						
	Parent(s)/Carer(s) Name(s):							
	Contact number (if different from home):							
<p>We need to ensure the safety of your child. To ensure us to do so please provide the name and telephone number below of any person authorized to collect your child:</p> <p>Name:</p> <p>Telephone No:</p>								
<p>Please provide details of two alternative contact names for your child in the event of us not being able to contact you should there be an emergency:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; padding: 5px;">Name:</td> <td style="width: 50%; padding: 5px;">Name:</td> </tr> <tr> <td style="padding: 5px;">Address:</td> <td style="padding: 5px;">Address:</td> </tr> <tr> <td style="padding: 5px;">Telephone No:</td> <td style="padding: 5px;">Telephone No:</td> </tr> </table>			Name:	Name:	Address:	Address:	Telephone No:	Telephone No:
Name:	Name:							
Address:	Address:							
Telephone No:	Telephone No:							
Doctor's name:  Address:  Telephone No:	Please indicate if your child has any dietary needs or allergies:							
Days you wish your child to attend: <table style="width: 100%; border: none; text-align: center;"> <tr> <td>Monday</td> <td>Tuesday</td> <td>Wednesday</td> <td>Thursday</td> <td>Friday</td> </tr> </table>			Monday	Tuesday	Wednesday	Thursday	Friday	
Monday	Tuesday	Wednesday	Thursday	Friday				
I hereby confirm that I wish my child to attend After School Club.								
Signed..... Date..... (Parent/Carer)								

**Moorlands C of E Primary Academy  
2018/2019**

**After School Club**

**Medical Consent Form**

I hereby authorize the leader in charge of the After School Club to which my child belongs to, in the absence of the parents, to give consent to any medical treatment (including blood transfusion or surgery) which in the opinion of a qualified medical practitioner may be necessary in the best interest of the child.

Name of Child(ren):

..... Date of birth.....

..... Date of birth.....

..... Date of birth.....

Signed..... Date.....

(Parent/Carer)