REGISTRATION FORM

Clondrohid Community Creche & Pre-School
Clondrohid,
Macroom,
Co. Cork.
Tel (026) 43344: email: clannairecreche@gmail.com

Child's Name
Date of Birth:
Home Address:

Home Phone No
Date of commencement:(Creche)
Date of Cesation of Creche:
Date of commencement:(Pre-School)
Date of cesation of Pre-School:

Name of Parent/Guardian:
Workplace Address:
Work place phone No:
Mobile Phone No:
E-mail Address:
Name of Parent/Guardian:
Workplace Address:
Work place phone No:
Mobile Phone No:
Person(s) Authorised to collect (other than parents/guardian)
Name:
Contact No:

Name:
Contact No:

Personal Datails:
Family Doctor:
Contact no:

Immunisation Record:

BCG	6 in 1 PCV Men B Rotavirus 2 Months	6 in 1 Men B Rotavirus 4 months	6 in 1 PCV Men C 6 months	MMR Men B 12 Months	Men C PCV HIB 13 Months	4 in 1 MMR 4-5 yrs

Did your child ever have any of the following?	Yes	No
Chicken Pox		

			Whooping Cough					
			Mumps					
			Rubella					

Does your child suffer from any medical conditions, disabilities or allergies, or dietary requirements?

____

____

____

Prescription Medicines I consent to prescribed medicines by oral administration and others (inhalers/ injectable adrenaline) in accordance with the policy and procedure of the service.

NB: Parents will always be asked to complete a medical consent administration form prior to the medicines been given.

Parent/Guardian's signature: ______________________________ Date: ___ / ___ / _____

Antipyretic / Anti-Febrile Medication I consent to the administration of teething gels and temperature control medication (Calpol/Paralink) in accordance with the policy and procedures of the service.

NB: Parents will always be informed when medication has been administered to their child.

Parent/Guardian's signature: ______________________________Date: ___ / ___ / _____

Allergies My child has an allergy to a temperature control medication (e.g. Calpol/paralink): Yes __ No ___

If so, please give details: ______________________________

Infectious Diseases I will notify the service as soon as possible if my child is diagnosed with an infectious disease e.g. measles, viral meningitis, Diphtheria, Whooping cough.

Parent/Guardian's signature: ______________________________ Date: ___ / __ / _

In the case of of an emergency do you consent to have your child taken to doctor/hospital?

I/We give permission to the staff/management of Clann Aire to act on my behalf in the case of an emergency or accident and to take such actions as may be necessary for the benefit my child. **yes / no** please circle one

Parent/Guardian Name; ______________________________

Supervisor/Manager Signature: ______________________________ Date: ___ / ___ /_

In hearby give permission for my child's photograph to be taken and used for promotion of our services in newspapers or local or national publications

yes / no please circle one

Parent/Guardian Name; ______________________________

Supervisor/Manager Signature: ______________________________ Date: ___ /___ / .

In hearby give permission for my child's photograph to be taken and used for promotion of our services on our website **yes / no** please circle one

Parent/Guardian Name; ______________________________

Supervisor/Manager Signature: ______________________________ Date: ___ /___ /_

Photo and Video Permission I give permission for____________________ (childs name) to be photographed or video recorded. **Yes** **No**

Photographs/videos may be used for:	**Yes**	**No**
Documenting learning e.g. Observations, Learning Stories		
TUSLA Early Years Inspectorate/ DES Inspectorate		

Service Evaluation									
Displays and information									
Share a photo on Child Paths or Class DoJo with other parents of your child playing									
with the children in their pod/group/class									
If we would like to use a photo / video of your child for another purpose, we will ask for specific permission.									
Parent/Guardian's signature:___________________________________ Date: ___ / ___ / _____									