SEASHELLS NURSERY ELCC
Community Centre, Albert Road
Eyemouth, TD14 5DE
Seashellsnursery@hotmail.co.uk
018907 52082

APPLICATION FORM

SURNAME OF CHILD	
FIRST NAME	
KNOWN AS	
DATE OF BIRTH	
BIRTH CERTIFICATE NO.	/ /
HOME ADDRESS	
TELEPHONE NUMBER	
MOBILE PHONE NUMBER	
EMAIL ADDRESS	

FAMILY DETAILS

PARENTS/CARERS NAME		PARENTS/CARERS NAME	
ADDRESS IF DIFFERENT FROM ABOVE		ADDRESS IF DIFFERENT FROM ABOVE	
DAY TIME TELEPHONE NUMBER		DAY TIME TELEPHONE NUMBER	
POSITION OF CHILD IN FAMILY (E.G 1 OF 2)	OF		

PLEASE TICK SESSIONS REQUIRED (MINIMUM 2 PER WEEK)

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
MORNING					
LUNCH					
AFTERNOON					

START DATE REQUESTED

CONSENT SHEET

TO PROVIDE THE BEST CARE FOR YOUR CHILD WHILE THEY ARE AT SEASHELLS NURSERY, WE HAVE COMPILED A LIST OF THINGS THAT REQUIRE YOUR CONSENT. PLEASE TICK THE FOLLOWING BOXES TO AUTHORISE CONSENT.

	PLEASE TICK
I AGREE TO ALLOW MY CHILD TO GO ON OUTINGS AROUND THE TOWN ON FOOT OR IN THE PUSHABLE KIDDYBUS WITH SEASHELLS NURSERY.	
I AGREE TO MY CHILD'S PHOTOGRAPH BEING TAKEN, EITHER FOR USE IN THE NURSERY AS PART OF THE CURRICULUM, TO BE FEATURED IN LOCAL PRESS (NO NAMES WILL BE USED), AND ALSO FOR USE IN SEASHELLS NURSERY.	
I ALLOW SEASHELLS NURSERY STAFF TO PROVIDE BASIC FIRST AID TO MY CHILD IN THE EVENT OF AN ACCIDENT.	
I AGREE TO THE SEASHELLS NURSERY ALLOWING EMERGENCY MEDICAL TREATMENT TO COMMENCE IN MY ABSENCE (I.E. GP/999).	
I ALLOW MY CHILD TO TAKE PART IN THE NATIONAL TOOTHBRUSHING PROGRAMME FOR 2-5 YEARS OLDS.	
I AGREE TO SUPPLY SUNCREAM FOR MY CHILD AND ALLOW SEASHELLS STAFF TO APPLY IT.	
I UNDERSTAND THAT SEASHELLS NURSERY WILL INFORM MY CHILD'S HEALTH VISITOR OF MY CHILD'S START DATE AND FINISH DATE AT SEASHELLS NURSERY.	

(PLEASE NOTE THAT ADMINISTRATION OF MEDICATION IS A SEPARATE ISSUE, PLEASE SPEAK TO A MEMBER OF STAFF IF THIS APPLIES TO YOUR CHILD)

MEDICAL DETAILS

DOCTOR'S NAME	
HEALTH VISITOR	
ADDRESS	
TELEPHONE NUMBER	

IS YOUR CHILD'S IMMUNISATION RECORD UP TO DATE	YES	NO

HAS YOUR CHILD HAD ANY OF THE FOLLOWING ILLNESSES? PLEASE TICK.

CHICKEN POX		WHOOPING COUGH	
GERMAN MEASLES		CROUP	
MEASLES		MUMPS	

ARE THERE ANY OTHER SERVICES INVOLVED WITH YOUR CHILD AT PRESENT? (E.G. SPEECH AND LANGUAGE THERAPY, EDUCATIONAL PSYCHOLOGY, SOCIAL WORK DEPARTMENT, CHILDREN & FAMILY SERVICES).

NAME		CONTACT DETAILS	
NAME		CONTACT DETAILS	
NAME		CONTACT DETAILS	

(THIS IS TO ALLOW CONTINUITY OF CARE FOR YOUR CHILD WHILST MAINTAINING CONFIDENTIALITY AND GOOD COMMUNICATION BETWEEN SERVICES AT A UNIVERSAL LEVEL).

DOES YOUR CHILD ATTEND ANY G.P./CLINIC/HOSPITAL REGULARLY FOR ANY REASON?
IF YES, PLEASE GIVE DETAILS

HAS YOUR CHILD HAD ANY OTHER ILLNESSES OR DO THEY SUFFER FROM ANYTHING ELSE THAT WE SHOULD KNOW ABOUT, EG. ASTHMA, ALLERGIES ETC. IF SO PLEASE STATE BELOW

EMERGENCY CONTACTS (DIFFERENT NUMBERS TO ALREADY GIVEN PLEASE)

NAME	
RELATIONSHIP TO CHILD	
ADDRESS	
TELEPHONE NUMBER	

NAME	
RELATIONSHIP TO CHILD	
ADDRESS	
TELEPHONE NUMBER	

SECURITY

PLEASE LIST HERE, WHO MAY PICK UP YOUR CHILD (MUST BE AGED OVER 18)

1.	2.
3.	4.
5.	6.

IF A CHILD IS TO BE COLLECTED BY A NAMED PERSON ON THE ABOVE LIST PLEASE PROVIDE A PASSWORD FOR EXTRA SECURITY AS EACH MEMBER OF STAFF MAY NOT RECOGNISE THE PERSON COLLECTING.

PLEASE LET US KNOW IF THE PERSON COLLECTING YOUR CHILD WILL BE DIFFERENT FROM THE PERSON WHO BRINGS THEM AND INFORM THEM OF THE PASSWORD.

IS THERE ANYONE WHO IS NOT ALLOWED CONTACT YOUR CHILD I.E. ESTRANGED PARENT?

IF THERE IS ANYONE WHO IS NOT ALLOWED CONTACT WITH YOUR CHILD, YOU MUST GIVE US A COPY OF A COURT/LEGAL DOCUMENT OR A LETTER FROM YOUR LEGAL REPRESENTATIVE FOR YOUR CHILD'S FILE THAT DETAILS THIS. ALL DETAILS WILL BE STORED CONFIDENTIALLY.

NAME OF THE CHILD	
NAME PARENT/CARER	

SIGNED		DATE