

TODDLERS' UNIVERSITY

CHILD INFORMATION SHEET

To be completed by the parent/carer or person with parental responsibility and handed in to the Nursery before the child attends.

CHILD'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

TELEPHONE: _____

Names of Brothers and/or Sisters attending: _____

Parent(s)/Carers(s) or Persons(s) with parental responsibility:

Name: _____

Relationship: _____

Home Address: _____

Home Tel: _____

Work Address: _____

Work Tel: _____

Mobile: _____

e-mail: _____

Emergency Contact(s):

Name(s) of Person(s) who will collect the child:

Name: _____

Relationship: _____

Tel: _____

Mobile: _____

ETHNIC ORIGIN: I consider the named child's origin to be:-

African-Caribbean	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	Mixed Asian/White	<input type="checkbox"/>
African	<input type="checkbox"/>	Other Asian	<input type="checkbox"/>	Mixed Other	<input type="checkbox"/>
Indian	<input type="checkbox"/>	Mixed African	<input type="checkbox"/>	White	<input type="checkbox"/>
Caribbean/White	<input type="checkbox"/>	Other	<input type="checkbox"/>		

RELIGION: I consider the named child's religion to be:-

Hindu	<input type="checkbox"/>	Christian	<input type="checkbox"/>	Other	<input type="checkbox"/>
Sikh	<input type="checkbox"/>	Jewish	<input type="checkbox"/>	None	<input type="checkbox"/>
Muslim	<input type="checkbox"/>	Buddhist	<input type="checkbox"/>		

DISABILITY: I consider one or more of the following applies to the named child:-

Learning Impairment	<input type="checkbox"/>	Speech Impairment	<input type="checkbox"/>	More than one	<input type="checkbox"/>
Visual Impairment	<input type="checkbox"/>	Physical Disability	<input type="checkbox"/>	None	<input type="checkbox"/>
Hearing Impairment	<input type="checkbox"/>				

1ST LANGUAGE: _____ **2ND LANGUAGE:** _____

HEALTH:

Child's Doctor: _____ Tel. No: _____

Doctor's Address: _____

Health Visitor: _____ Tel. No: _____

Health Clinic Address: _____

VACCINATIONS/IMMUNISATIONS:

Diphtheria	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Polio	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>
Whooping Cough	<input type="checkbox"/>	Rubella	<input type="checkbox"/>		

Infectious Illnesses: _____

Any prescribed medication (including dosage): _____

Any special diet, allergies, health problems or anything else the staff should know about the child: _____

SESSIONS REQUIRED:

	Mornings	Afternoons
Mondays	_____ DO/PU*	_____ DO/PU*
Tuesdays	_____ DO/PU*	_____ DO/PU*
Wednesdays	_____ DO/PU*	_____ DO/PU*
Thursdays	_____ DO/PU*	_____ DO/PU*
Fridays	_____ DO/PU*	_____ DO/PU*

* If applicable please also indicate drop-off (DO) and pick-up (PU) requirements/times from local schools.

Name of School: _____ Tel No: _____

Address of School: _____

Name of Teacher: _____ Class: _____

Signed: _____ Date: _____
(Parent/Guardian or Person with Parental Responsibility)

