

# Childcare Centre Application Form

Name  Address

Surname

Date of Birth           Town

Gender  boy  girl E-mail  Post Code

Mother's Name  Father's Name

## Service Applying for: Childcare

- |  |                                    |
|--|------------------------------------|
| <input type="checkbox"/> 10 hours weekly (minimum) | <input type="checkbox"/> Monday    |
| <input type="checkbox"/> 15 hours weekly           | <input type="checkbox"/> Tuesday   |
| <input type="checkbox"/> 20 hours weekly           | <input type="checkbox"/> Wednesday |
| <input type="checkbox"/> 30 hours weekly           | <input type="checkbox"/> Thursday  |
| <input type="checkbox"/> 40 hours weekly           | <input type="checkbox"/> Friday    |
|  | <input type="checkbox"/> Saturday  |

## One month / Term deposit

Make cheque payable to **Stepping Stones**

*Applications will be accepted on a first-come-first-served basis and must be accompanied by a one term payment. Acceptance will be confirmed in writing.*

## Pick-Up Authorisation

Name the persons authorised to pick up your child. No other person will be able to do so without the parent/guardian's consent. (Kindly include yourself)

Name & Surname	ID Card No.	Relationship to child
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

## Emergency Contact details

Please ensure that you include the correct details of the persons who may be contacted in case of emergency

Name & Surname	Mobile No.	Fixed Line No.
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

# Medical History

Please answer all questions carefully

1. Does your child have any type of allergy?

Yes

No

If yes specify:

2. Has your child ever had an operation/injury?

Yes

No

If yes please describe it:

If yes, in which month and year did it occur?

3. Does your child have specific dietary needs?

Yes

No

If yes specify:

4. Is your child under prescription medicine?

Yes

No

If yes specify drug:

Dosage:

5. Please describe any other health condition or physical condition of your child (or any other conditions) about which we should be informed

  
  
  

The data requested will only be processed by the administration of Stepping Stones for the general administration of the centre and for the correspondence with participants themselves. Under no circumstances will this data be passed on to commercial parties. All this information is required so that, should the need arise, procedures may be carried out without unnecessary delays. In case of an accident or emergency, Stepping Stones Administrator will attempt to contact the person listed in the Emergency Contact Details. If no one can be reached the responsibility of your child's health will be assumed by the doctor.

I/We wish to receive information about further Stepping Activities

I/We am/are granting Stepping Stones permission to use images of my/our child in future Stepping Stones promotional material and media coverage of Stepping Stones activities

Parents/Guardian's name

ID Card

Date

Telephone Home

Mobile

Workplace

Workplace Phone  
& Extention

Kindly attach the following documents of your child where relevant

Birth Certificate

Immunization records

Prescriptions

Signature