# 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 2 Months | 6 in 1 + Men C 4 months | 6 in 1 + PCV+Men C 6 months | MMR + PCV 12 Months | Men C + 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 Medicine**s 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 within reason in consultation with the parent/guardian. **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 with other parents of your child playing with their children e.g. small / large group | | |

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: ___ / ___ / _____