

Application Form

Child's FIRST name (likes to be known as)

Child's SURNAME

Date of birth (DD/MM/YY) Male / Female

Address.....

.....

Nationality Ethnic Origin

Language spoken at home Religion

Parent's name (#1)

Address (if different from child)

.....

Mobile Home

Email

Parent's name (#2)

Address (if different from child)

.....

Mobile Home

Email

Primary email address for correspondence

Primary email address for invoices

EMERGENCY name
and contact no.:

Relationship to child : _____

Preferred session days/times: (Breakfast club 8am-9am)

TIME	MON	TUE	WED	THURS	FRI
8:00 – 9:00	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9:00 – 12:00	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9:00 – 14:00	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14:00 – 17:00	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Free Entitlement only sessions: *subject to availability

TIME	MON	TUE	WED	THURS	FRI
9:00 – 14:00 *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14:00 – 17:00	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Preferred start date



Special dietary requirements? YES / NO

Please specify
.....

Food Allergy? YES / NO

Please specify
.....

Drug/ Substance Allergy? YES / NO

Please specify
.....

Inhaler used? YES/ NO

Please specify

Has the child received his/her routine vaccinations? YES / NO
(Diphtheria, Tetanus, Whooping Cough, Polio, Measles/MMR)

Does the child have any special needs / disabilities YES / NO

Please specify
.....
.....

Record of Infectious Diseases
.....
.....

GP Details

GP name
Surgery Address
.....
Surgery Telephone Number
Child's Health Visitor

Please give below the name, address & telephone number of any schools/nurseries previously attended by the child
.....
.....

Please tell us how you first heard of us

I apply for the child named to attend Horsham Montessori Nursery. I confirm that I understand and agree to the terms stated in the Fees, Finance & Funding Policy.

I confirm I have paid the Registration Fee* of £50 (£25 siblings) by BACS / Cheque (please add £1.50 Bank Charge) / Cash (please circle as appropriate) (* Not applicable to FE places)

Signature

Name

Date

