

Caversham Primary After School Club Application Form

Basic Information

Name of Child:	<input type="text"/>	Child's Class:	<input type="text"/>
Date Of Birth:	<input type="text"/>	Billing Address:	<input type="text"/>
Billing Name:	<input type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	
Email Address:	<input type="text"/>		
<input style="width: 80%; margin: 0 auto;" type="text"/>			

Ad hoc Sessions:

I acknowledge that all adhoc sessions are chargeable at the standard sessional rates and agree to the payment for all sessions in advance of attendance at the club.

Please tick box in agreement with the statement above.

Regular sessions:

Monday	<input type="checkbox"/>
Tuesday	<input type="checkbox"/>
Wednesday	<input type="checkbox"/>
Thursday	<input type="checkbox"/>
Friday	<input type="checkbox"/>

Date of first Session:

Contact Details

Parent/Carer contact details for After School Club. Please list in Order of Priority, so we contact people in the correct order.

	Full Name (Mr, Mrs etc)	Relationship to Child	Work Phone	Home Phone	Mobile
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Dietary Needs

Please indicate if there are any foods that your children must not eat due to allergic reaction, cultural or religious beliefs:

Medical Details

NHS No: Doctor:

Surgery:

Please give de-
tails of any significant medical condition that may be relevant:

give consent for first aid to be administered to my child:

I give consent for emergency services to be called in event of an accident:

I agree to the terms & conditions document, as available on the school website:

Signed: (parent/carer) Date: