



MARIAN MISSION EDUCATIONAL AND FAMILY SUPPORT CENTRE

REGISTRATION FORM

ENTRY PROFILE

Early Years & Childcare Service

1. Name of Child: Male • Female

Name Child will be known as:

2. Date of Birth:

SEND : Is the child in receipt of DLA? Y N

3. Main Address:

.....

4. Phone (home).....

5. Additional Address:

Phone (home):

6. Name of Parent/Carer/Guardian.....

Work/College Address.....

.....

Name Known by at work/college.....

Phone (work):Phone (mobile).....

Email:

D.O.B: NI:.....

Name of Parent/Carer/Guardian.....

Work/college address.....

.....

Name known by at work/college.....

Phone(work):Phone (mobile).....

Email:.....

D.O.B: NI:.....

Who has parental responsibility?

National Insurance No./s of the Responsible Parent/s:

7. Name(s) of all children in the family in age order:

Name	DOB	Name	DOB
1.		4.	
2.		5.	
3.		6.	

8. Position in family: • 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8

8. Race/ethnicity: Child

Family.....

9. Language(s) understood by child:

Language(s) spoken by child:

Language(s) understood by family:

Language(s) spoken by family:

Does family require translation and in which language?

10. Religion:

Festivals family celebrates:

11. Person(s) authorised to collect the child (emergency contacts):

Name:.....

Address:

Phone.....

Name:.....

Address:.....

Phone:.....

12. Person(s) NOT authorised to collect or have access to the child: Name (1):

Name (2):.....

Context: (e.g.
injunction nr.).....

13. Previous care history and/or access to any programmes or facilities e.g.

Childminder, parent & Toddler group, Toy library etc:

Provider name:Address: (if known)

Provider name:Address: (if known)

14. General Practitioner:

Name: Address:

..... Phone:

.....

Health Visitor:

Name: Clinic:

..... Address:

..... Phone:

.....

15. (recorded in the PCHR – red book)

Immunisations	Date
B.C.G. (at birth)	
Diphtheria	
Tetanus	
Whooping Cough	
Hib	
Oral Polio vaccine	
Men C	
Measles, Mumps and Rubella	
Pre-School Booster	
Additional inoculations (please specify): 1. 2.	

16. Development checks includes 2 year old check (last check with HV/GP):
 Age in months Date

17. Any important health considerations?
 Please give details and any special requirements the setting needs to undertake to support the child's needs. (Include possible use of asthma inhaler/EpiPen etc., future appointments etc.)

 Are there any allergies e.g. penicillin, plasters, anaesthetic, food allergies, wasp stings/insect bites?
 Details.....

18. Does the child require other aids/adaptations, feeding utensils e.g. cups/cutlery?
 • Yes (please give details).....
 • No

19. Have any additional needs been identified?

- Yes / No

If Yes, please specify (including any known diagnosis)

.....

Known to Child Development Team (CDT) ?

20. Has any additional support been provided to meet the identified areas of need?

Yes / No

If Yes, at what level (graduated response)?

EY SEND Plan and Outcomes in place?

Request for Additional funding to support child's needs?

Referral to external professionals (EP, SACC, CDT, SALT)?

Request for an EHCP?

EHCP in place?

Which areas of development have been identified for additional support?

Has any Early Help Assessment (EHA) ever been completed with you?

- YES
- No

Date:

Has a Team Around the Child (TAC) been established? Yes No

If Yes, please name team members (including co-ordinator) Has

Early Help Support Programme (E HSP) been initiated? Yes No

Is there an SEND support Plan or Education Health Care Plan? Yes No

21. Are there other specialist agencies working with your family to support your child's development e.g. PORTAGE team, SALT, Social Care etc.? Yes No

If yes, please indicate who they are.....

22. History:

birth history, prematurity, time spent in hospital, separation, bereavement or any other important events?

.....

23. Dietary requirements e.g. breast feeding, weaning, food allergies, likes/dislikes?

.....

24. Toileting requirements: key words known/used by child, nappies, potty trained, toilet Trained

.....

25. Sleeping requirements: key words, comforter, pattern.

.....

26. Cultural/religious dress requirements:

.....

27. Tell us about your child's development and what s/he and can do/what they enjoy playing with:

Information checklist

Please tick discussed/information given:

30. Safeguarding information

31. Medication procedure

32. Accident procedure

33. Complaints procedure

34. After-hours procedures

35. Behaviour management/relationship policy

36. Settling in process discussed and agreed

37. Future school admission

38. Records, observations and information kept

39. Statutory 2-year-old progress review

Permissions

40. I give permission for my child to be taken to hospital for treatment in the event of an emergency

Signature Date

41. I give permission for my child to be given medication as prescribed by my GP, dentist nurse or pharmacist and will provide written consent for each and every new medication to be given:

Signature Date

42. I give permission for my child to be taken on local outings:

Signature Date

43. Should my child require additional support I give permission for the nursery to work in partnership with the Area SENCO/and/or Early Years Education Psychology Service.

Signature Date

44. I give permission for my child to have photographs/videos taken for the learning record:

Signature Date

45. I give permission for my child to be transported by the Childminder/Setting in the vehicle used for this purpose:

Signature Date

46. I give permission for my child's records (safeguarding & SEND) to be passed on to the next setting, as part of my child's transition arrangements:

Signature Date

47 I give permission for my child's SEND records to be passed on to the next setting, as part of my child's transition arrangements:

Signature Date

Form completed by:

Provider Signature Date

Parent/Carer Signature Date