

## REGISTRATION FORM

<b>SURNAME:</b>	<b>FORENAMES:</b>
<b>ADDRESS:</b>	<b>TELEPHONE:</b>
<b>POSTCODE:</b>	<b>DOB:</b>
<b>DOES YOUR CHILD HAVE SPECIFIC ADDITIONAL NEEDS?</b>	<b>DAYS/SESSIONS ATTENDING:</b>
<b>OTHER PROFESSIONALS INVOLVED?</b>	MON <span style="float: right;">DAY/AM/PM</span>
	TUES <span style="float: right;">DAY/AM/PM</span>
	WEDS <span style="float: right;">DAY/AM/PM</span>
	THURS <span style="float: right;">DAY/AM/PM</span>
	FRI <span style="float: right;">DAY/AM/PM</span>
Please let us know if you need any info on above benefits	
<b>MOTHER'S NAME:</b>	<b>FATHER'S NAME:</b>
<b>HOME ADDRESS IF DIFFERENT FROM ABOVE:</b>	<b>HOME ADDRESS IF DIFFERENT FROM ABOVE:</b>
<b>MOTHER'S PLACE OF WORK:</b>	<b>FATHER'S PLACE OF WORK:</b>
<b>TELEPHONE:</b>	<b>TELEPHONE:</b>
<b>MOBILE:</b>	<b>MOBILE:</b>
<b>NAME &amp; ADDRESS OF CHILD'S G.P.:</b>	<b>NAME OF HEALTH VISITOR:</b>
<b>TELEPHONE:</b>	<b>TELEPHONE:</b>
<b>DOES YOUR CHILD HAVE ANY HEALTH RELATED PROBLEMS OR ALLERGIES ?:</b>	<b>DOES YOUR CHILD HAVE ANY DIETARY REQUIREMENTS ?:</b>
<b>CHILD'S RELIGION:</b>	<b>ETHNIC ORIGIN</b>
<b>EMAIL ADDRESS:</b>	
<b>NAMES &amp; NUMBERS OF AT LEAST 2 OTHER PEOPLE WHO MAY BE CONTACTED IN AN EMERGENCY:</b>	
1/	2/
<b>PASSWORD:</b>	
<b>WHERE DID YOU HEAR ABOUT CLOCKWORK DAY NURSERY ?:</b>	
<b>DATE:</b>	<b>START DATE:</b>
	<b>SIGNATURE:</b>