ADVENTURE CLUB
QUALITY OUT-OF-SCHOOL CARE

Registration Form
(Orchard Primary School)

Section 1 Child's Details

Child's Surname: _____
Child's First Names: _____
Preferred name: _____ Sex _____
Child's Date of Birth: _____(Day) _____Month _____ (Year) Age_____
Home Address: _____
_____
_____
_____Postcode_____
School attended _____

Section 2 – Parent(s)/Carer(s) Details

Name (Parent 1) _____
Role _____
Address _____
_____
_____Postcode_____

Occupation _____

Home telephone number _____
Work telephone number _____
Mobile telephone number _____
E-mail Address _____

Name (Parent 2) _____
Role _____
Address _____
_____
_____Postcode_____

Occupation _____
Home telephone number _____
Work telephone number _____
Mobile telephone number _____
E-Mail Address _____

OFSTED RATING 'GOOD'

Section 3 - Additional Information

Does your child have any medical needs? Yes [ ] No [ ]

Is your child on any long term medication? Yes [ ] No [ ]

If yes please state and explain special requirements

_____

_____

Please complete the 'Health Care' form if you have answered yes to any of the above questions.

Does your child have any special needs Yes [ ] No [ ]

If yes please state (Continue on additional sheet if necessary)

_____

_____

Does your child have any dietary needs? Yes [ ] No [ ]

If yes please state (please continue on additional sheet if necessary)

_____

_____

Section 4 – Emergency Contacts and Others Who May Collect Your Child

Emergency Contact 1

Name: _____

Relationship: _____

Telephone Number: _____

Mobile Number: _____

Home address: _____

_____

_____Postcode_____

Emergency Contact 2

Name: _____

Relationship: _____

Telephone Number _____

Mobile Number: _____

Home address: _____

_____

_____Postcode: _____

Who else may collect your child?

Name _____

Relationship _____

Address _____

_____

_____Postcode_____

Telephone _____ Mobile _____

Password

A password will be required when picking up your child. The same password must be provided by everyone picking up your child. Please provide us with a password below:

Password: _____

Section 5 – Child's Doctor's Details

Child's doctor is: Dr. _____

Surgery Address: _____

Contact Number: _____

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Section 6 – Photograph Permission

Photography is used as a way of recording children's involvement in activities. We are however aware that there may be circumstances in which you wish your child's photograph not to be taken. Please indicate your permission by ticking the relevant option below.

[ ] I give consent to photographs of my child being taken at Adventure Club
[ ] I do not give consent to photographs of my child being taken at Adventure Club

Section 7 - Sun Cream

Younger children may need support to apply sun cream in hot weather. Please indicate your permission for Adventure Club to support your child by selecting the relevant option below.

[ ] I give permission to Adventure Club to support my child to apply sun cream
[ ] I do not give permission to Adventure Club to support my child to apply sun cream

Section 8 – Face Painting

Activities include face painting. Please indicate our permission for face painting below.

[ ] I give permission for my child to be included in face painting activities.
[ ] I do not give permission for my child to be included in face painting activities.

Section 9 – Declaration

I understand that the Club activities include making short trips to the park or other outings, and I agree to my child taking part.

I consent to any emergency medical treatment necessary during the running of the Club and authorise the staff to sign any form of consent required by medical staff, if a delay in getting my signature could endanger the child's Health or Safety.

I have read the club's policies/terms and conditions and agree to abide by the terms and conditions.

Signed. _____ Date _____

Section 10 – Survey

Please tick the appropriate box below to tell us how you heard of Adventure Club.

School [ ] Friend [ ] Other [ ] Please state _____

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HEALTH CARE PLAN

(Only to be completed if your child has an ongoing medical condition with a healthcare plan)

Child's Name: _____Date of Birth: _____

Medical Diagnosis or Condition

_____

_____

Medical Contact Name: _____

Contact Number:_____

GP's Name:_____ GP's Contact_____

Surgery Name:_____

Surgery Address:

_____

_____

_____

Describe the medical needs of your child and give details of your child's symptoms

_____

_____

_____

Please give details of daily care requirements including action and time or situation in which care is needed.

_____

_____

_____

Give details of what constitutes an emergency for your child

_____

_____

_____

What action/s should be taken if this occurs: (List order in which actions should be taken

_____

_____

_____

Who is responsible in an emergency?

_____

_____

Parent/Carer's Name (Please Print): _____

Parent/Carer's Signature: _____ Date: _____

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Medication Administration Form

Child's Details

Child's Name:_____ Age: _____
Known Allergies:_____

Medication Details

Prescription Medication
Medicine Name: _____
Prescribed by: Doctor [ ] Pharmacist [ ] Qualified Nurse [ ]
Date medicine was dispensed: _____
Name as it appears on medicine: _____
Dosage: _____ Expiry date: _____
Refrigeration Required? Yes [ ] No [ ]

Over-the-counter Medication

Medicine name: _____ Expiry date: _____
Doses already given today: _____

Medication Administration

Dosage 1: _____ Time Administered: _____
Name of person administering medication:_____
Signature: _____
Comments _____
Dosage 2: _____ Time Administered: _____
Name of person administering medication:_____
Signature: _____
Comments _____
Dosage 3: _____ Time Administered: _____
Name of person administering medication:_____
Signature: _____
Comments _____

Please record medication administration below if medication is a week's course.

	Dose	Time	Initial	Dose	Time	Initial	Dose	Time	Initial
Mon									
Tue									
Wed									
Thurs									
Fri									

Parental Consent
I give permission for the above medication to be administered to my child. I have provided all information required in relation to the administration of the medication provided. I have read the mediation policy and agree to its content.

Parent's Name (Please Print): _____ Signature: _____

Acknowledgement
I acknowledge the medication administered to my child as above.
Parent's Name (Please Print): _____ Signature:_____