**SET YOUR SIGHTS BEFORE AND AFTER SCHOOL CLUB REGISTRATION FORM**

**To be completed and emailed to office@setyoursights.net**

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Name of Child:……………………………………………………………………………………………

Child’s Date of Birth:………………….… Child’s Class:………………………………………..…….

Child’s Home Address:………………….…………………………………………..…………….…….

……………….…………………………………………..……………….……..………………..……….

My child has the following medical conditions/allergies/dietary requirements (please complete a medical form for any regular medication we may need to administer i.e. inhaler, epipen):

………………………………………………………………………………………………………………

………………………………………………………………………………………………………………

My child has an asthma inhaler at school: YES/ NO

My child has Special Educational Needs (SEN)? YES/ NO

If Yes, please give details ………………………………………………………………………………..

………………………………………………………………………………………………………………

My child is a Looked After Child (LAC)? YES/ NO

My child has English as an additional language (EAL)? YES/ NO

If yes, what would you say is child’s primary language? ……………………………………………..

Do you give consent for a member of Set Your Sights staff to accompany your child to the hospital in an emergency? YES/NO

Name of Parent/Guardian …………………………………………………………………..…

Mobile Number:……………………………………………………….

Work Number:…………………………………………………………

Home number………………………………………………………….

Other emergency contact:…………….………………………………

Contact Email Address:………………………………………………………………………………..

Name of Parent/Guardian …………………………………………………………………..…

Mobile Number:……………………………………………………….

Work Number:…………………………………………………………

Home number………………………………………………………….

Other emergency contact:…………….………………………………

Contact Email Address:……………………………………………………………………………………..

Other Registered Collectors ………………………………………………………………………….…..…

………………………………………………………………………….…..…………………………………

Any Forbidden Collectors ………………………………………………………………………….…..…

Collection Password for 3rd Parties …………………………………………………………………..…

In case of emergency, please provide below your child’s registered doctors details

Registered Doctor:……………………………………………………………………….

Surgery:………………………………..…………………………………………………

Telephone Number:……………………….……………….…………………………….

I allow / do not allow (please delete as appropriate) Queen’s Hill Primary School and Set Your Sights to share and discuss information about my child relating to the following areas:

* Child Protection
* Special Educational Needs (SEN)
* Behaviour Management
* Management of account including payment and emergency contacts
* Access to medical information and medicines

I also give / do not give (please delete as appropriate) Set Your Sights permission to contact me with regards to my registration and account

Signed: ……………………….……………….…………………………….

Date: ……………………….……………….……………………………….