**SET YOUR SIGHTS REGISTRATION FORM**

**To be completed and emailed to** office@setyoursights.net **along with your booking requirements.**

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

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

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

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

Name of Parent/Carer Registering Child………………………..…………………………………

Relationship to child:…………………………………………………

Mobile Number:……………………………………………………….

Work Number:…………………………………………………………

Home number………………………………………………………….

(Please provide at least 2 contact telephone numbers)

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

Does the child live at the home address above with you: YES / NO

If no, please provide your home address:………………….………………………..………………

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

Name of Additional Parent/Carer …………………………………………………………………..…

Relationship to child:…………………………………………………

Mobile Number:……………………………………………………….

Work Number:…………………………………………………………

Home number………………………………………………………….

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

Is the primary home address above applicable to this parent/carer: YES / NO

If no, please provide home address:………………….………………………..……………………

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

Any additional contacts in an emergency?……………………………………………………………

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

Collection Password …………………………………………………………………..………………….

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

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

Do you give consent for a member of Set Your Sights staff to accompany your child to the hospital in an emergency? 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? ……………………………………………..

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

Doctors 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

By submitting your registration form to Set Your Sights (office@setyoursights.net), you provide a virtual signature to complete your registration and give electronic permission for Set Your Sights to contact you with regards to your registration and account.

Date: ……………………….……………….……………………………….