



THREE LEGGED CROSS FIRST & NURSERY SCHOOL

Church Road, Three Legged Cross, Wimborne BH21 6RF

Contact: office@3lxschool.com; 01202 822460

Admission Form

INFORMATION ABOUT THE CHILD

LEGAL NAME	Surname	Forename(s)
DATE OF BIRTH		Gender (M/F)
ADDRESS		
POST CODE		

INFORMATION ABOUT THE CHILD'S PARENTS, OR OTHERS RESPONSIBLE FOR THE CHILD

PARENT'S FULL NAME		Do you have legal parent responsibility? *	
ADDRESS IF DIFFERENT FROM CHILD'S			
HOME NUMBER			
MOBILE NUMBER			
WORK NUMBER		PLACE OF WORK	
EMAIL ADDRESS			

PARENT'S FULL NAME		Do you have legal parent responsibility? *	
ADDRESS. IF DIFFERENT FROM CHILD'S			
HOME NUMBER			
MOBILE NUMBER			
WORK NUMBER		PLACE OF WORK	
EMAIL ADDRESS			

PARENTAL RESPONSIBILITY

WHO HAS PARENTAL RESPONSIBILITY FOR THE CHILD? *
1.
2.

NAME OF OTHER PERSON			
RELATIONSHIP TO CHILD			
ADDRESS			
TELEPHONE NUMBERS	Home		Mobile
Is the child living with you by virtue of:	Residence order	<input type="checkbox"/>	Care Order <input type="checkbox"/>
If YES which Local Authority is responsible			
Emergency Protection Order	<input type="checkbox"/>	Being a Private Foster Parent	<input type="checkbox"/>
		Being a legally appointed guardian	<input type="checkbox"/>
<i>If you have answered yes to any of the five categories above, please provide a legal document to confirm this</i>			

* If the child is born after 1993 and the birth father is not married to the mother, they do have parental responsibility.

EMERGENCIES – Please give details below of anyone who could be contacted if your child becomes ill during the school day. This should include your own daytime telephone number. Please list the names in order of priority and Indicate relationship to child, i.e. Parent, Aunt, Neighbour etc.

FULL NAME		RELATIONSHIP	DAYTIME TELEPHONE NUMBERS
1			
2			
3			
4			

PUPIL PREMIUM/FREE SCHOOL MEAL VOLUNTARY REGISTRATION

	Parent/Guardian 1	Parent/Guardian 2
LAST NAME		
FIRST NAME		
DATE OF BIRTH		
ADDRESS (IF DIFFERENT FROM CHILD)		
NATIONAL INSURANCE NO.		
NASS NUMBER		

MEDICAL INFORMATION

DOCTORS NAME			
DOCTORS ADDRESS			
TELEPHONE NUMBER		NHS NO.	
SPECIAL DIET NEEDED			
ANY KNOWN ALLERGIES			
ANY OTHER MEDICAL CONDITIONS OF WHICH SCHOOL SHOULD BE AWARE			

In the event of the school being unable to contact me/us or any of the contact numbers given above, I hereby give permission for my child to receive emergency treatment at the surgery/hospital should the need arise.

Signed Date

PREVIOUS SCHOOLS

Name and address of previous school/nursery	Date of admission DD/MM/YY	Date of Leaving DD/MM/YY

PERSON COMPLETING THE FORM

NAME	Surname	Forename
RELATIONSHIP TO CHILD		
	All information given on this form is correct to the best of my knowledge	
SIGNATURE	Signed	Date

PLEASE NOTIFY THE SCHOOL OFFICE OF ANY CHANGE OF INFORMATION