



56-58 Shepherd Street
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CHILD'S INFORMATION:			
Full Name:		Date of Birth:	
Known as:		Gender:	
Address:			
	Postcode:		
Is she/he used to leaving parents/carers? NO <input type="checkbox"/> YES <input type="checkbox"/>			
Is she/he known at other nursery settings? NO <input type="checkbox"/> YES <input type="checkbox"/>			
If YES, When and Where?			
Collection Password:			

TOILETING:			
Is she/he wearing nappies?	NO <input type="checkbox"/>	YES <input type="checkbox"/>	PULL UPS <input type="checkbox"/>
Is she/he completely dry?	NO <input type="checkbox"/>	YES <input type="checkbox"/>	
Do they ask to go toilet?	NO <input type="checkbox"/>	YES <input type="checkbox"/>	
Do they prefer to use?	POTTY <input type="checkbox"/>	TOILET <input type="checkbox"/>	

DIETRY:	
Does she/he prefer to drink at snack?	WATER <input type="checkbox"/> SEMI-SKIMMED MILK <input type="checkbox"/>
She/he able to use a cup?	NO <input type="checkbox"/> YES <input type="checkbox"/> If NO preferred choice:.....
Does she/he have food requirements?	NO <input type="checkbox"/> YES <input type="checkbox"/> (PLEASE TICK BOXES BELOW)
Vegetarian	<input type="checkbox"/>
Halal	<input type="checkbox"/>
Vegan	<input type="checkbox"/>
Gluten Free	<input type="checkbox"/>
Allergies	<input type="checkbox"/> (Please fill in allergies section) Other <input type="checkbox"/>

MEDICAL AND SPECIAL NEEDS:

Childs NHS Number:

Has your child had their 2-year-old review with health visitor? NO YES

YES: Date of review:

NO: Reason:

Is she/he up to date with immunisations? NO YES

If NO, reason?

Does she/he have any Allergies? NO YES

How are the allergies treated? (E.g.: medicine, epi-pen)

Is she/he on any regular medication? NO YES Does she/he have any special care? NO YES Has she/he been referred to any service for further investigation or support?
(e.g. speech therapy, health professional, social services or others) NO YES

Service Provider:

Details:

Do you have any concerns about your child learning and development? NO YES

Details:

LANGUAGE & CULTURAL INFORMATION

What language(s) does your child speak or hear at home?

What is your child's first/main language?

Does your child understand English? NO YES A LITTLE

Does your child speak English? NO YES A LITTLE

What language(s) does Parent/Carer 1 speak?

What language(s) does Parent/Carer 2 speak?

Do you require translation or support with communication? NO YES

If yes, please specify preferred language & how we can support?

Country of origin/cultural background?

Child:

Parent/Carer(s)1:

Parent/Carer(s)2:

PARENT/CARER INFORMATION:			
Parent/Carer 1:		Relationship to Child:	
Full Name:		Gender:	
Address:			
(Same as child <input type="checkbox"/>)	Postcode:		
Home telephone:			
Mobile:			
Email address:			
Work Telephone:			
Does this person have parental responsibility? NO <input type="checkbox"/> YES <input type="checkbox"/>			
Does this person have legal access to the child? NO <input type="checkbox"/> YES <input type="checkbox"/>			

Parent/Carer 2:		Relationship to Child:	
Full Name:		Gender:	
Address:			
(Same as child <input type="checkbox"/>)	Postcode:		
Home telephone:			
Mobile:			
Email address:			
Work Telephone:			
Does this person have parental responsibility? NO <input type="checkbox"/> YES <input type="checkbox"/>			
Does this person have legal access to the child? NO <input type="checkbox"/> YES <input type="checkbox"/>			

EMERGENCY CONTACT INFORMATION:			
Full Name:		Relationship to Child:	
Address:			
	Postcode:		
Home telephone:			
Mobile:			

PREFERRED SESSIONS:

*Funded 15 hours: 9-12 OR 1-4

*Funded 30 hours: 9-3

*Private Paying:

Funded 15hours Funded 30hours Private pay

Monday		Tuesday		Wednesday		Thursday		Friday	
9-12	1-4	9-12	1-4	9-12	1-4	9-12	1-4	9-12	1-4
<input type="checkbox"/>									

ID SEEN AND VERIFIED:

Child's Birth Certificate:		Document Number:	
Child's Red Book:			
Parent/Carer Photo ID			
Checked by staff member:			Date:

ADDITIONAL INFORMATION: