DATA COLLECTION SHEET

Surname:		Legal Surname:	
Forename:		Middle Name:	
Chosen Name:		Gender	
Date of Birth:		Reg Group:	
Address:			
Post Code:			

Please give details of all persons who have **parental responsibility** and anyone else you wish to be contacted in an emergency. Place them in the order that you wish for them to be contacted in an emergency

Name/Relationship	Home address	Work Address
	Phone No Mobile No Email Address	Phone No Mobile No
	Phone No Mobile No Email Address	Phone No Mobile No
	Phone No Mobile No Email Address	Phone No Mobile No
Brothers or Sisters already in school:	Name:	Class:

Medical Conditions:	
Doctor:	
Address:	
Telephone:	
Authorisation for Plasters	YES / NO

Has your child received any treatment for any of the following Epilepsy – Asthma – Any Allergy – or other conditons?

If YES, please give details? ……..

……

Authorisation for tasting different foods YES/NO
If any allegies please state

…….

……..

Does you child wear glasses? YES / NO

Do you suspect any hearing or speech problems? YES /NO

I do/do not give permission for St Paul's First School staff to assist my child to change clothes and with any toilet related changing.

I understand I need to contact my child's class teacher to make a Health Plan before my child starts school. YES / No

Ethnicity (Please tick as appropriate)

Bangladeshi	Pakistani	Indian	White & Asian	Other Asian
Black African	Black Caribbean	White & Black African	White & Black Caribbean	Other Black
White British	White Irish	Other White	Gypsy/Roma	Irish Heritage
Chinese	Mixed Background	Other ethnic Group		
Home Language:				
Regligion:				

Signed Parent/Guardian …….

Date…….

St Paul's C of E (C) First School

Early Parent Concerns

Confidential Information

Help us to help your child gain most benefit from his/her school days – trust us with information.

It is important for your child's education that you keep us up to date of any information that may effect their academic progress. Therefore Please come and talk with us at any time.

Please talk with us.

Child's Name: _____

Date of Birth: _____

Have you any concerns about your child's development?

YES NO

Has your child experienced any difficulties
YES NO

do you have any concerns about my child's development or behaviour
YES/NO

If yes, please explain.

Has any concern been expressed by –

a) Health Visitor? YES/NO

Name: _____

b) Doctor? YES/NO

Name: _____

c) Has your child been referred to a – Paediatrician? YES/NO

Speech Therapist? YES/NO

Educational Psychologist? YES/NO

Other? YES/NO

If yes, who/what/when?

Has a playgroup, nursery or school expressed concern?
YES/NO

If yes, please give details.

If you have any concerns or others have expressed concerns and you would Prefer to talk to us – please call in or telephone to make an appointment.

Signature: _____

Date: _____

Name: _____ Parent/Guardian

Thank you