Enrolment form

Footsteps Day Nursery
64b Station Road
Chingford
London
E4 7BA

If you have any questions, please call us on 020 3583 5741
or e-mail us at chingford@footsteps-nurseries.com

Please complete using block capitals with as much detail as possible

Child's full name: _____
Date of birth / EDD: _____
Religion: _____
Ethnicity _____
Sex: Male □ Female □
Home address: _____
(This must be their usual _____
address of residence) _____
_____
Home phone {Inc area code} _____
Languages spoken at home: _____

Title: _____
Parent 1 full name: _____
Relationship to child _____
Parental Responsibility (Yes/No) _____
Address: _____
{If different from above} _____
Home phone number: _____
Mobile number /s: _____
e-mail address: _____
Job title: _____
Company name: _____
Work address: _____
_____
_____
Work phone number / s: _____
Work department: _____
Days at work: _____
Hours of work: _____

Title: _____
Parent 2 full name: _____
Relationship to child _____
Parental Responsibility (Yes/No) _____
Address: _____
{if different from above} _____
_____
Home phone number: _____
Mobile number /s: _____
e-mail address: _____
Job title: _____
Company name: _____
Work address: _____
_____
_____
Work phone number / s: _____
Work department: _____
Days at work: _____
Hours of work: _____

Title: _____
Any other guardian full name: _____
Relationship to child: _____
Parental Responsibility (Yes/No) _____
Address: _____
{if different from above} _____
Home phone number: _____
Mobile number /s: _____
e-mail address: _____
Job title: _____
Company name: _____
Work address: _____
_____
_____
Work phone number / s: _____
Work department: _____
Days at work: _____
Hours of work: _____

emergency contact name
Grandparents, friends etc : _____
Relationship to child: _____
Does this person have ongoing permission to collect your child from nursery?
Please circle YES NO
Address: _____
_____
_____
Home phone number: _____
Mobile number /s: _____
Pager / other number: _____
Job title: _____
Company name: _____
Work address: _____
_____
_____
Work phone number / s: _____
Work department: _____
Days at work: _____
Hours of work: _____
e-mail address: _____
Password for collection of
your child: _____
Can this password be used if someone else is picking your child up *i.e. friend, aunt, uncle* etc please circle YES NO

Child's doctors name: _____
Address of surgery: _____
_____
_____
Phone number: _____
Medical history: _____
_____
_____

Immunisation to date:

2 months	Diphtheria, Tetanus, Whooping Cough {DTaP}, Polio {IPV} Hib + Pneumococcal conjugate vaccine {PCV} DATE GIVEN: _____
3 months	Diphtheria, Tetanus, Whooping cough {DTaP}, Polio {IPV} Hib, Meningitis C DATE GIVEN: _____
4 months	Diphtheria, Tetanus, Whooping cough {DTaP}, Polio {IPV} Meningitis C, PCV DATE GIVEN: _____
12 months	Hib, Meningitis C DATE GIVEN: _____
13 months	MMR, PCV DATE GIVEN: _____
3 years 4 months plus	MMR 2nd dose, 4-in-1 (DTaP/IPV) pre-school booster, DATE GIVEN: _____

Any special diet due to health, allergies, religious or cultural reasons please state dietary requirement and reason for this:

_____
_____
_____
_____

Are there any other agencies involved? Please circle YES NO
(*Doctor, dietician, speech & language, physiotherapist, social services etc)*

If yes what are they and what is the reason:_____
_____
_____

Their name: _____
Address: _____
_____
_____
_____

Phone number: _____

Continues from above if needed:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Exact start date required: _____
{please note, full fees will be charged from this date}

Sessions required: **Mon** AM □ PM □ **Tues** AM □ PM □ **Wed** AM □ PM □ **Thurs** AM □ PM □ **Fri** AM □ PM □

Full day sessions are 7.30am – 6pm, half day sessions are 8am-12pm or 2pm-6pm.

Deposit paid: Amount:_____ Date: _____ Method: _____