



Tregoze
· Primary School ·
Inspire · Motivate · Challenge

Tregoze Toucans After School Club



ADMISSION FORM

Admission Form

Tregoze Primary School, Sleaford Close, Swindon SN5 6JU

Telephone: 01793 876800

Tregoze Toucans

ADMISSION FORM

- **3:15-6pm Monday-Friday - £10.00 per session**
 - **Snack provided**
 - **Safe and stimulating environment**

For more information, visit

The Tregoze Primary School Office

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ADMISSION FORM

Child's Full Name:

Name to be used at Toucans:

Date of Birth:

Ethnicity: **Religion (if any):**

Languages Spoken:

Name of Parent/Main Carer(s):

Home Address:

Telephone Number:

Parent/Carer Place of Work:

Daytime Number:

Other Emergency Contact Details:

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TOUCANS COLLECTION FORM

PLEASE GIVE THE NAMES OF TWO OTHER PEOPLE THAT MAY COLLECT YOUR CHILD/CHILDREN

(Please be aware that anyone other than your child's parent or main carer will need to say a password before they are able to collect your child)

Name	Name
Address	Address
Contact Number(s)	Contact Number(s)
Relationship to Child	Relationship to Child

Code Password:

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TOUCANS CONSENT INFORMATION

Consent form for emergency First Aid

I/We give permission for my child to receive emergency First Aid when necessary

Consent form for Photographs

I/We give permission for my child to have their photographs taken during sessions at Tregoze Toucans Club. (Photos taken will **not** be displayed outside of Tregoze Primary School, unless permission has been given otherwise)

Please tick the relevant boxes to allow these pictures to be:

- Displayed on School Noticeboards

- In School Newsletters

- Used for the promotion of Toucans and Tregoze Primary School

Signature: **Date**.....

Print Full Name: **Parent/Carer**.....

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TOUCANS PERMISSION TO ADMINISTER MEDICATION CONSENT FORM

I/We give permission for my child to receive the named prescribed medicines, as per the information below, by a member of the Toucans Staff.

Please note: we are unable to administer unprescribed medication.

Name of Child	Medication to be Administered	Dosage to be Administered	Time to be Administered	Actioned by (Staff)

Signature: **Date**.....

Print Full Name: **Parent/Carer**.....

TOUCANS ASC ALLERGY/SPECIAL DIET INFORMATION

Foods not Allowed:
Further Details: (including reason for special diet)
Allergies:
Symptoms:
Treatment:
Parents Signature:
Date:
Staff Signature:
Date:

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