Infant School, Mourne Road, Drimnagh, Dublin 12

Application for Enrolment for Junior Infants: September ……………year

Name of your Child: ____ Boy □ Girl □ (please tick √)

Date of Birth: __________________________ Place in Family _______________ Religion: _______________

Address:____

Telephone: ____ Landline No. __________________________

Nationality/Country of Origin: ___________________________ PPS No. ______________________________

Mothers Name & Address Fathers Name & Address

_____________________________ _________________________________

_____________________________ _________________________________

Mobile: ________________________ Mobile: ____________________________

In the event of an emergency /your child becoming ill during school time who should the school contact if no one at home? :

Name(s) & contact phone number(s) : ____

____

Has your child any medical conditions or illness/allergies/problems etc that the school should be aware of ?: Yes □ No □

If YES please give details: ____

____

Has your child special education needs? Yes □ No □ If YES – please give details and provide copies of assessment /reports etc.

____

Has your child attended preschool? Yes/No

If YES give Name & Address of Preschool: ____

Please read the following statements carefully before signing the form

- I have read and signed the MEDICAL CONSENT FORM overleaf . YES/NO (please circle)
- I agree that, if the school considers it appropriate my child's photograph (without name) and /or school work may be chosen for inclusion on the school website – www.infantschoolmourneroad.net YES/ NO (please circle)
- I agree to support the School Code of Behaviour – copy available to all parents/guardians YES (please circle)

Signed:_______________________________________ Parent/Guardian. Date:_____________

Don't forget to please enclose a copy of your child's Birth Certificate with this application **©Infant School 2012**

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MEDICAL CONSENT FORM IN EVENT OF EMERCENCY

In the event of illness or accident to my child

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in the Infant School

and

in the event of I not being at home to take my child for treatment,

I hereby authorise the school authorities to do so

and

further authorise the doctor/hospital to administer such treatment as is necessary to save my child' life or even reduce grave pain for my child's ultimate wellbeing.

Signed: ________________________________ Parent/Guardian

Address: ____

Contact Phone Nos. ____

FAMILY DOCTOR: ____

Address & Phone no of DOCTOR: _______________________________________

Significant medical history /allergies etc for my child

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