



Kids Inc Head Office, 1st Floor, Palmerstown Shopping Centre, Palmerstown, Dublin 20
Phone: 01-6215790 Email: info@kidsinc.ie

AFTER SCHOOL APPLICATION FORM

Please note we require that you complete all sections in the application form

Child's Details

Name:

Address:

D.O.B:

Home Tel:

Parent(s) 1. Ph mobile:.....

E-mail:

2. Ph mobile:

E-mail:

Home address for either parent if different from child:

.....

Who does your child live with?

School Name:

Class:

KIDS INC Location:

Additional information that might help us to get to know your child better:

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Please select from options below:

Junior/Senior infants

After School Club 1.45pm – 6.30pm

Please tick your preference below:

- 5 days
- 4 days Mon Tues Wed Thurs Fri
- 3 days Mon Tues Wed Thurs Fri
- 2 days Mon Tues Wed Thurs Fri

After School Club 1:45pm-4:30pm

- 5 days
- 4 days Mon Tues Wed Thurs Fri
- 3 days Mon Tues Wed Thurs Fri
- 2 days Mon Tues Wed Thurs Fri

1st class – 6th class

After School Club 2.45pm – 6.30pm

Please tick your preference below:

- 5 days
- 4 days Mon Tues Wed Thurs Fri
- 3 days Mon Tues Wed Thurs Fri
- 2 days Mon Tues Wed Thurs Fri

After School Club 2:45pm – 4:30pm

- 5 days
- 4 days Mon Tues Wed Thurs Fri
- 3 days Mon Tues Wed Thurs Fri
- 2 days Mon Tues Wed Thurs Fri

Sibling/Infant Club 1:40pm - 2:40pm

- 5 days

We are currently registering interest for before school club, please tick box if you are interested

Before School Club: 8am- until class starts (times may vary)

- 5 days

Please fill in Parent(s) employer details below

1. Parent Employer Details

Name: _____

Address: _____

Phone: _____

2. Parent Employer Details

Name: _____

Address: _____

Phone: _____

Person authorised to collect (Other than Parent)

Relationship to child: _____

Name: _____

Address: _____

Phone: _____

Person authorised to collect (Other than Parent)

Relationship to child: _____

Name: _____

Address: _____

Phone: _____

Please fill in medical and emergency contact details below:

Child's Doctor

Dr. Name: _____

Address: _____

Phone: _____

Emergency Contact Person (Other than parent)

Relationship to child: _____

Name: _____

Address: _____

Phone: _____

Any Allergies/medical conditions (Please Tick)

Yes

No

If "YES", please give details:

Description of Allergy/ Food intolerance/ Medical condition	Preventative Measures	Action taken should child become ill due to allergy/intolerance/medical condition	Have you received letter from Doctor or consultant confirming Allergy/intolerance/Medical condition? *please include date on letter & name of Doctor Please provide a copy of the letter from Doctor.

*Please note that information above must be reviewed annually or as changes in condition arise. Parents please keep your Child's Supervisor up to date on any changes in wellbeing or medical circumstances.

Does your child have any specific dietary requirements or food intolerances?

Yes No

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Is your child on any long term medication (Please Tick) Yes No

If "YES", please give details:

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Does your child suffer from any hearing and/or speech difficulties? (please give details)

Yes No

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.....

Name of siblings and position in family:

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Any fears and dislikes?

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Special Care and Attention (Please give details below, and discuss with centre manager)

- 1) If your child has a diagnosed additional need, we require additional medical records prior to confirming our suitability to meet his/her needs.
- 2) If you suspect your child may have need for extra support, please ensure you include as much detail as possible below so that we can ensure we are equipped to meet his/her needs.

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Additional Information to be completed:

Name of School:
School contact number:
Time of collection:
Class name from Sept 2019:
Teacher's Name (if known):

Accident and/or Emergency Consent Form

I/We _____ parent/guardian of (child's name) _____
give my permission to the management of Kids Inc to act on my behalf in case of emergency or
accident and to take such action to get any necessary medical attention for the benefit of my
child. Kids Inc will not sign for any medical treatments on my behalf

Signed: _____ Parent/Guardian Date: _____
Signed: _____ Parent/Guardian Date: _____
Signed: _____ Kids Inc. Manager Date: _____

Permission for Calpol and Nurofen Administration

I/we hereby give my/our permission for my child (child's name) _____
To be given fever reducing medicine in the event that I cannot be contacted.

Signed: _____ Parent/Guardian
Signed: _____ Parent/Guardian
Signed: _____ Kids Inc. Manager
Date: _____

Permission to be photographed or video recorded while in the care of the centre staff

I/we hereby give my/our permission for my child (child's name) _____
To be photographed or video recorded by Kids Inc. Staff for centre use only.

Signed: _____ Parent/Guardian
Signed: _____ Parent/Guardian
Signed: _____ Kids Inc. Manager
Date: _____

Permission for Outings

I/we hereby give my/our permission for my child (child's name) _____
to partake in walks and other outings outside the crèche grounds, on the understanding that the
adult/child ratio as recommended by the insurance company will be adhered to at all times.

Signed: _____ Parent/Guardian Date: _____

Signed: _____ Parent/Guardian Date: _____

Signed: _____ Kids Inc. Manager Date: _____

I /We are happy that this Application Form is fully completed. If any of the above information
changes I/We will notify the Manager.

IMPORTANT NOTICE

**Please ensure that where both parents are involved in the care of the child that
both signatures are provided below and where permissions are sought above.**

Signed: _____ Parent/Guardian Date: _____

Signed: _____ Parent/Guardian Date: _____

<p>Administration Details (Manager to Complete)</p> <p>Start Date: _____ Finish Date: _____</p> <p>Deposit of € _____ received in full by _____ on _____</p> <p>Payment method (Please tick): Cheque <input type="checkbox"/> Cash <input type="checkbox"/> Ref No. _____</p>

If you need assistance with any of the above, please contact Head Office.