



# **New Delaval Primary School**

## **Application Form**

### **Nursery Year 1-Year 6**



New Delaval Primary School  
Early Years/KS1 and KS2 Admission Form



# New Delaval Primary School - Admission Form

## 1. CHILD'S DETAILS

Child's Surname.....

Child's First names(s).....

Chosen Name/Known as name.....

Address.....

.....Postcode.....

Date of birth.....Gender (M/F).....

Name of previous school/Playgroup/Nursery .....

.....

Attended from.....Date left.....

Reason for Leaving.....

## 2. PARENT/GUARDIAN DETAILS

Please give details of all persons who have parental responsibility and place them in order you wish them to be contacted in an emergency.

\*Delete as appropriate

### 1<sup>st</sup> Contact

Name	
Relationship	
Occupation	
Mobile number	
Home address is different from above	
Home telephone number	
Parental responsibility	Yes/No*



**2<sup>nd</sup> CONTACT**

Name	
Relationship	
Occupation	
Mobile number	
Home address if different from above	
Home telephone number	
Parental responsibility	Yes/No*

**3<sup>rd</sup> CONTACT**

Name	
Relationship	
Occupation	
Mobile number	
Home address if different from above	
Home telephone number	
Parental responsibility	Yes/No*

**4<sup>th</sup> CONTACT**

Name	
Relationship	
Occupation	
Mobile number	
Home address if different from above	
Home telephone number	
Parental responsibility	Yes/No*



### 3. ADDITIONAL DETAILS – SIBLINGS AT SCHOOL

If your child has a sibling attending New Delaval Primary School, please give details below. *Please note a sibling is defined as a child of the family, sharing a parent by birth or adoption or living at the same address at the time of the application.*

Sibling's Full Name and Date of Birth .....

Sibling's Full Name and Date of Birth.....

Sibling's Full Name and Date of Birth .....

### 4. MEDICAL DETAILS

Name of Doctor .....Telephone Number.....

Name and Address of Surgery .....

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**Important-**Please give details below of any medical conditions

.....

.....

.....

Name of Dentist.....Telephone Number.....

Name and Address of Surgery.....

.....

### 5. TRAVEL AND MEAL ARRANGEMENTS/DIETARY NEEDS

Please tick appropriate box

Travel		Meal		Dietary	
Bicycle		Free School Meal		None	
Car		Home		Artificial Colouring Allergy	
Public Transport		School Meal		No Dairy Produce	
Walk		Packed Lunch		Gluten Free	
Taxi		Other		Kosher Foods Only	
Other				No Nuts Of Any Type	
				No Pork	
				Ramadan	
				Seafood Allergy	
				Vegetarian	



## 6. CULTURAL INFORMATION

Please study the list below and tick one box only to indicate the ethnic background of your child.

- |                          |                          |                            |                          |
|--------------------------|--------------------------|----------------------------|--------------------------|
| White- British/European  | <input type="checkbox"/> | Black – Caribbean heritage | <input type="checkbox"/> |
| Black – African Heritage | <input type="checkbox"/> | Black - other              | <input type="checkbox"/> |
| Indian                   | <input type="checkbox"/> | Pakistani                  | <input type="checkbox"/> |
| Bangladeshi              | <input type="checkbox"/> | Chinese                    | <input type="checkbox"/> |
| Any other minority group | <input type="checkbox"/> |                            |                          |

(please specify).....

Signed Parent/Guardian.....

Date.....

For School Use Only

Year Group	UPN	Admission Date	Initials and Date

