

**CHALFONT ST PRESCHOOL SCHOOL**

**Chalfont St Peter Community Centre**

**Gravel Hill**

**Chalfont St Peter SL9 9QX**

**Tel: 07582 995167**

**REGISTRATION FORM**

**Full name of child ...........................................................................................................**

**(please underline the name by which he/she is usually called)**

**Male/Female/ Non Binary**

**(please circle)**

**Date of birth ................................................Nationality ................................................**

**Religion .........................................................................................................................**

**Date of required entry ...............................................................(subject to availability)**

**Age at entry ..............................................................................**

**Name of previous school/nursery ................................................................................**

**(if applicable)**

**Is your child currently registered at a future Private Nursery/Setting? Yes No**

**Start Date of future setting (Nursery)……………………………………………………………………….**

**Where do you intend on your child going to Primary School Private/State?...........................................................................................................**

**Names of parents/carers ............................................................................................**

**Address ......................................................................................................................**

**...................................................................................................................................**

**Address of parent if different from above .....................................................................**

**......................................................................................................................................**

**Telephone number. Home .............................................................................................**

**Parent/Carer 1 name ....................................................... Tel.no....................................**

**Parent/Carer 2 name ……………………………………………………. Tel.no………………………………….**

**Parent/Carer 1 Email address………………………………………………………………………………………..**

**Parent/Carer2 Email address………………………………………………………………………………………….**

**Family doctor’s name and Tel no. ....................................................................................**

**Other languages spoken at home ....................................................................................**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Please Tick a minimum of 3 sessions** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| **Early Morning Drop Off (8.30am-9am)** |  |  |  |  |  |
| **Full Day (9am-3:00pm)** |  |  |  |  |  |
| **Morning Session (9am-12pm)** |  |  |  |  |  |
| **Afternoon Session (12:00pm-3:00pm)** |  |  |  |  |  |

**Requested sessions: please note that no guarantee can be given for the sessions you require or that they will be available. All places are allocated according to registration date and availability for the relevant age ranges.**

***A NON REFUNDABLE ADMINISTRATION FEE OF £50 IS REQUIRED WHEN RETURNING THIS FORM This does not apply if you are only registering for funded only places* We accept cash or direct payment 40-08-41 21418319**

**Signature of parent/carer ............................................................. Date………………………**