

Parent/Carer 1:	Title:	Forename:	Surname:	DOB:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Country of Origin:		English Spoken: <input type="checkbox"/> Yes <input type="checkbox"/> No		Other Language Spoken:		
Do you have any disabilities/special needs: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state (please see sheet attached for definitions): Band A <input type="checkbox"/> Band B <input type="checkbox"/> Band C <input type="checkbox"/>						
Main Contact Address:	Is this address: Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>		Email Address:			
Address:				Town:	Postcode:	
Telephone Number:		Mobile Number:		Emergency Contact Number:		
Parent/Carer 2: (if appropriate)	Title:	Forename:	Surname:	Telephone/Mobile Number:		
Does 2 nd Parent/Carer live at same address: <input type="checkbox"/> Yes <input type="checkbox"/> No If different to above please state Address:						
Is Parent / Carer 2 present? * <input type="checkbox"/> Yes <input type="checkbox"/> No *If 2 nd parent /carer has not signed the form, give letter regarding registration & Tick if given <input style="width: 30px; height: 15px;" type="checkbox"/>						
If the 2nd parent is present please fill in the data below for both parents and indicate P1 and P2 (Parent 1 and Parent 2)						

Are you? Please tick all boxes that apply

<input type="checkbox"/> Parent	<input type="checkbox"/> Lone Parent	<input type="checkbox"/> Pregnant	If yes give due date:			
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Teenage Parent	<input type="checkbox"/> Smoker	<input type="checkbox"/> non smoker		<input type="checkbox"/> ex Smoker	Date quit:
<input type="checkbox"/> Living with Parents	<input type="checkbox"/> Foster Carer	<input type="checkbox"/> Other	Does anybody else in your household smoke?		Yes / No	Relationship to child:

We might seem to ask a lot of information but this enables us to design services which are right for all Children's Centre users so please help us by filling in the form.

Are you? Please tick

<input type="checkbox"/> Working – (0-15hrs)	<input type="checkbox"/> Working – (35hrs +)	<input type="checkbox"/> Working on a casual basis	<input type="checkbox"/> Higher / Further Education	<input type="checkbox"/> Not Working or training
<input type="checkbox"/> Working – (16 – 35hrs)	<input type="checkbox"/> Asylum Seeker	<input type="checkbox"/> Claiming JSA / ESA	<input type="checkbox"/> Maternity Leave	<input type="checkbox"/> Retired
<input type="checkbox"/> Self Employed	<input type="checkbox"/> Declined to answer	<input type="checkbox"/> Volunteering		

CONSENT

I understand that the information I have provided will be used to provide early education, health, family support and advice to improve services for my family. I understand that the Children's Centre may share my family's information with partnering organisations for those purposes only. **I agree to my family's details being held on the Calderdale Softsmat databases. Calderdale MBC is registered with the Information Commissioners Office and information is stored in line with the Data Protection Act (1998).** I agree to my files being used for the purpose of audit with associated organisations. I understand that if I would like to have a copy of my family's records, I must make a request in writing to the Early Years Learning and Childcare Service Manager, Learning Services.

Please read the Children's Centre Confidentiality Code Below before signing this form: Children's Centre practitioners are bound by an agreed code of confidentiality. Having gained consent, in the instance of sharing personal and family information they will inform the parent/individual of the reasons why it is being shared, exactly who will be informed and where the information will go. Exceptions to this will only be to; a) safeguard a child from harm/abuse of some kind (either physical or emotional) in line with the Calderdale Safeguarding Children's Board – b) any breaches of government security – c) risk to harm self or others.

In order to evidence the benefits that Children's Centre services have on families, we would like permission to track your child/ren through groups and into school Yes No

Signed (1st parent/Carer): _____ **Date:** _____ **Signed (2nd Parent/Carer):** _____ **Date:** _____

Please give DOB if you are 2nd Parent/Carer: _____

Staff Member Completing Form: _____ Position: _____

Source of Registration: _____ Date of Registration: _____

Date of Input on CCM: _____ Signed (Inputter): _____

Note for Inputter: Add all information on CCM, but do not tick registered or add DOB for 2nd parent/carers if they have not signed this form.

Other Services

Would you like an introductory visit	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes please fill in relevant paperwork:
Are you and your family registered with a GP?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes please state which one:
Are you and your family registered with a Dentist?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes please state which one:
Do you know who your Health Visitor is?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes please state which one:
Do you know who your Midwife is?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes please state which one:
Did you/ or are planning on breastfeeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes please state for how long:
Do you have any other services supporting your family?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes please state which:
Are there any special requirements needed for your family when attending services?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes please state below.

CHILDREN & YOUNG PEOPLE UNDER 18

(If more than 4 children please continue on to the continuation sheet)

Child 1				Please Tick					
Forename	Surname	DOB	Disability/Special Needs Yes / No Band A B C	Breastfed Birth 6wks		Safeguard Register/CAF, CIN, CP, LAC, TAC	Gender M / F	Relationship to 1 st Parent/Carer	Relationship to 2 nd Parent/Carer
School/ Nursery attended:									
Child 2				Please Tick					
Forename	Surname	DOB	Disability/Special Needs Yes / No Band A B C	Breastfed Birth 6wks		Safeguard Register/CAF, CIN, CP, LAC, TAC	Gender M / F	Relationship to 1 st Parent/Carer	Relationship to 2 nd Parent/Carer
School/ Nursery attended:									
Child 3				Please Tick					
Forename	Surname	DOB	Disability/Special Needs Yes / No Band A B C	Breastfed Birth 6wks		Safeguard Register/CAF, CIN, CP, LAC, TAC	Gender M / F	Relationship to 1 st Parent/Carer	Relationship to 2 nd Parent/Carer
School/ Nursery attended:									
Child 4				Please Tick					
Forename	Surname	DOB	Disability/Special Needs Yes / No Band A B C	Breastfed Birth 6wks		Safeguard Register/CAF, CIN, CP, LAC, TAC	Gender M / F	Relationship to 1 st Parent/Carer	Relationship to 2 nd Parent/Carer
School/ Nursery attended:									

Ethnicity (please tick)													
	Carer 1	Carer 2	Child 1	Child 2	Child 3	Child 4	Carer 1	Carer 2	Child 1	Child 2	Child 3	Child 4	
A White							C Indian						
British							Pakistani						
Irish							Bangladeshi						
Other White (includes Eastern Europe)							Other Asian						
B Mixed							D Black or Black British						
White & Black Caribbean							Black Caribbean						
White & Black African							Black African						
White & Asian							Other Black						
Other Mixed							E Chinese or other ethnic group						
							Chinese						
							F Other group, State:						
							G Rather not say						
English Spoken	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	English Spoken	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

FOR STAFF USE ONLY

Disability

If someone filling in the form declares a disability please ask them to indicate which group it falls in

A	<p>Parent/Young Person/Child with Autistic Spectrum Disorder (who have severe learning disabilities or behaviour which is challenging) or those children and young people whose challenging behaviour is associated with other impairments such as severe learning difficulties.</p> <p>General Rule: Any mental impairment which has a substantial and long term adverse effect on a child's ability to carry out normal day-to-day activities.</p>	
B	<p>Parent/Young Person/Child with complex health needs including those with a disability and life limiting conditions, and/or those who require palliative care and/or those with associated impairments such as cognitive or sensory impairments and /or have moving/handling needs and/or require special equipment/adaptations.</p> <p>General Rule: Any physical impairment which has a substantial and long-term adverse effect on a child's ability to carry out normal day-to-day activities.</p>	
C	<p>Where a Parent/or a Parent feels their child has a condition but yet to be diagnosed, confirmed or registered.</p>	