

Drop & Shop REGISTRATION & BOOKING FORM

Please ensure that all areas of this form are completed

Child's First Name	Surname	Gender	Age
Date of Birth	Address	Home Language	
<p>Doctor's Surgery:</p> <p>Doctor's Name:</p> <p>Surgery Address:</p>			
<p>Please Specify Medical Conditions (Including Allergies) <i>*If there is a risk of anaphylaxis you must complete a separate emergency plan</i></p>			
<p>Any Special Needs or Other Relevant Information:</p>			
<p>Date and Location of Session Booked:</p>			
Parent / Guardian Information:			
Full Name:	Relationship:	Mobile Phone Number:	
<p>Location on Day of Event (To be re-confirmed on the day):</p>			

SECOND Emergency Contact (if person named above cannot be contacted)		
Full Name:	Relationship:	Mobile Phone Number:
Daytime Address:		

ALTERNATIVE Emergency Contact:		
Full Name:	Relationship:	Mobile Phone Number:
Daytime Address:		

Consent Form

I hereby consent to my child attending the “Drop and Shop” event and understand that it is an “Open Access Scheme” exempt from Ofsted registration under “Annex A section 15” of the Early Years and Childcare Registration Handbook July 2016, No. 150150.

I consent to my child receiving emergency medical care if required. This would include first aid and any emergency dental, medical or surgical treatment as considered necessary by the medical authorities present in the best interest of my child.

I consent to Home Ed Hub taking photographs of my child during activities and that these can be used for the promotion of its business whether online or in printed literature, in line with their terms, conditions, and policies.

I consent to being contacted via email, text, or post with future information about Home Ed Hub services. You may opt out at any time.

I have read and accept the booking terms and conditions, as well as the policies and procedures (available to view at <http://www.homeedhub.com/bookings>).

All information is provided in confidence and will not be shared with any third party.

Signed..... Print Name.....

Date..... Email Address:.....

Checklist:

Payment To: Sort Code 40-09-18 Account 82122030

Registration and Consent Form Signed

Sibling Discount Applicable

EpiPen Authorisation* Signed if Applicable

* See next page.

Please email completed forms to: info@homeedhub.com

INDIVIDUAL ANAPHYLAXIS EMERGENCY PLAN FOR:

*Please attach a recent photograph for identification purposes

Signs and Symptoms

A person having an anaphylactic reaction may have **ANY** of the signs or symptoms listed below, even if they have not previously experienced the symptom before. **Known or expected signs and symptoms for this child are checked below**, however, staff should be on alert for any of these symptoms:

- Difficulty in swallowing or speaking.
- Difficulty in breathing – severe asthma
- Swelling of the throat and mouth
- Hives anywhere on the body or generalised flushing of the skin
- Abdominal cramps, nausea and vomiting
- Sudden feeling of weakness (drop in blood pressure)
- Alterations in heart rate (fast Pulse)
- Sense of Impending doom (anxiety/panic)
- Collapse and unconsciousness

Please list any other symptoms Home Ed Hub staff must watch for in order to administer an EPI Pen if necessary due to an allergic reaction. *Please include instructions for use:*

As the Parent / Guardian of the above named child, I hereby give permission to Home Ed Hub staff to administer an EPI Pen to my child, if needed, according to the instructions above. I fully understand that staff may not be formally qualified to do so and I accept full responsibility.

Signed..... Print Name.....

Date.....