



A SureStart Children's Centre

Family I.D. No:

Family registration form for Sure Start Children's Centres

The information you give us will help us to make sure that you get information about Sure Start Children's Centre services and events that are relevant to you. It will also help us to monitor and evaluate our services. We may contact you and send you information about our services and events.

The more information you give us, the easier it will be for us to send you relevant information. However, you only need to answer the questions in the grey boxes.

Information about you as the legal guardian or person with parental responsibility

Title	Mr/ Mrs/ Miss/ Ms/ Dr	Marital Status	<input type="checkbox"/> Divorced <input type="checkbox"/> Living with Partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed
First name/s		Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Middle name		If yes, when is your baby due?	
Surname		Telephone mobile	
Address		Email address	
	Postcode	Date of Birth	
Telephone home		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Name and address of your GP?			
	Postcode		

Are you a lone parent? (You do not have a partner living in the family home)	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<p>The details given on this form are true to the best of my knowledge. I have the legal right to provide this information.</p> <p>I consent to my photo or image and that of my child/ren being used to promote and publicise children's centres in a variety of formats including television, newspapers, video, posters, leaflets, internet and other medium which will allow this children's centre to promote the work it does. Images will not be used for any other purpose.</p> <p>Please tick the box if you do not consent <input type="checkbox"/></p>	
Parent/carer name	
Parent/carer signature	
Date	

<p>Do you have a job? Yes, I am employed or self-employed for <input type="checkbox"/> Less than 16 hours per week <input type="checkbox"/> More than 16 hours per week Are you currently on maternity leave? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>No, I am unemployed and <input type="checkbox"/> Not looking for a job <input type="checkbox"/> Looking for a job <input type="checkbox"/> Full time parent/carer <input type="checkbox"/> Full time student</p>
<p>Do you receive any of these benefits? (Please tick all that apply) <input type="checkbox"/> Incapacity <input type="checkbox"/> Income Support <input type="checkbox"/> Job Seekers Allowance <input type="checkbox"/> Pension Credit <input type="checkbox"/> Severe Disability Allowance <input type="checkbox"/> Other</p>

<p>Ethnicity (Please tick the appropriate box to indicate your ethnic group)</p>
<p>A White <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> European <input type="checkbox"/> Gypsy/Roma <input type="checkbox"/> Traveller of Irish Heritage <input type="checkbox"/> Any Other White Background</p>
<p>B Mixed/Dual Background <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Asian <input type="checkbox"/> Any Other Mixed Background</p>
<p>C Asian or Asian British <input type="checkbox"/> Pakistani <input type="checkbox"/> Indian <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any Other Asian Background</p>
<p>D Black or Black British <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other Black Background</p>
<p>E Chinese or other ethnic group <input type="checkbox"/> Chinese <input type="checkbox"/> Other (please specify)</p>
<p><input type="checkbox"/> Prefer not to say</p>

<p>Do you consider yourself to have a special need?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Do you consider yourself to have a disability?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Do you live in temporary housing (provided because you were made homeless)?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>What language/s do you Speak? Read? Write?</p>	<p>What is your level of English? <input type="checkbox"/> Conversational <input type="checkbox"/> Fluent <input type="checkbox"/> Interpreter required</p>
<p>Do you smoke?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Have you or your child/ren been to a Sure Start Children's Centre before? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If yes, which one/s?</p>

Data Protection Act 1998 *Wellspring* (the 'Centre') respects your privacy rights and is committed to ensuring that it protects your details, the information about your dealings with the Centre and other information available to the Centre ('your information'). In accordance with the Data Protection Act 1998, the Centre will use your information, for the purpose of providing support to children, to (a) deal with your requests and administer its functions, (b) meet its statutory obligations, and (c) prevent and detect fraud. The Centre may share your information (but only with the minimum amount of information necessary to do the above and only where it is lawful to do so) with appropriate departments and agencies in accordance with the Multi Agency Information Sharing Protocol (MAISP). Further details, including a copy of the MAISP can found at www.surreycc.gov.uk

If you would like to apply for access to the information we hold about you please send a written request to *Moira Allen, Coordinator for Wellspring CC, Bookham Baptist Church, Lower Road, Bookham, KT23 4DH.*

Information about the child or children in your family (those you have parental responsibility for)

Please fill in one section for each child

FIRST CHILD

First name/s		Ethnicity (Please tick the appropriate box to indicate your child's ethnic group) A White <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> European <input type="checkbox"/> Gypsy/Roma <input type="checkbox"/> Traveller of Irish Heritage <input type="checkbox"/> Any Other White Background B Mixed/Dual Background <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Asian <input type="checkbox"/> Any Other Mixed Background C Asian or Asian British <input type="checkbox"/> Pakistani <input type="checkbox"/> Indian <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any Other Asian Background D Black or Black British <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other Black Background E Chinese or other ethnic group <input type="checkbox"/> Chinese <input type="checkbox"/> Other (please specify) <input type="checkbox"/> Prefer not to say
Middle name		
Surname		
What is your relationship to this child?	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Other (please specify)	
Date of birth		
National Health Number		
School child attends (if applicable)		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	

Do you consider your child to have a special need?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you consider your child to have a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child live at the same address as you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, what is their address?	
Postcode	

Are you, or did you, breast feed your child? (Please tick all that apply) <input type="checkbox"/> Yes, from birth to less than 6 weeks <input type="checkbox"/> Yes, from birth to 6 weeks <input type="checkbox"/> Yes, from birth to 3 months <input type="checkbox"/> Yes, from birth to 6 months <input type="checkbox"/> Yes, from birth to 12 months <input type="checkbox"/> Yes, from birth to over 12 months <input type="checkbox"/> Still breast feeding <input type="checkbox"/> No, did not breast feed
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Did you get a free pack of books for your child (Bookstart pack)? (Please tick all that apply) <input type="checkbox"/> Yes, Bookstart pack 0 – 12 months <input type="checkbox"/> Yes, Bookstart pack 12 – 24 months <input type="checkbox"/> Yes, Bookstart Treasure Chest 2 – 3 years (given out by Early Years settings) <input type="checkbox"/> No, did not receive Bookstart pack
Child's weight at birth

Please give details of any other adult who is legal guardian, or who has parental responsibility, for this child (we may contact them for more information).

Name of Adult	
Date of Birth	
Address	
	Postcode

Telephone home	
Telephone mobile	
What is their relationship to this child? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Other (please specify)	

I understand that if I am providing personal information for other people, it is my responsibility to inform them of this.

Information about the child or children in your family (those you have parental responsibility for)

Please fill in one section for each child

SECOND CHILD

First name/s		Ethnicity (Please tick the appropriate box to indicate your child's ethnic group) A White <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> European <input type="checkbox"/> Gypsy/Roma <input type="checkbox"/> Traveller of Irish Heritage <input type="checkbox"/> Any Other White Background B Mixed/Dual Background <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Asian <input type="checkbox"/> Any Other Mixed Background C Asian or Asian British <input type="checkbox"/> Pakistani <input type="checkbox"/> Indian <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any Other Asian Background D Black or Black British <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other Black Background E Chinese or other ethnic group <input type="checkbox"/> Chinese <input type="checkbox"/> Other (please specify) <input type="checkbox"/> Prefer not to say
Middle name		
Surname		
What is your relationship to this child?	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Other (please specify)	
Date of birth		
National Health Number		
School child attends (if applicable)		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	

Do you consider your child to have a special need?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you consider your child to have a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child live at the same address as you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, what is their address?	
Postcode	

Are you, or did you, breast feed your child? (Please tick all that apply) <input type="checkbox"/> Yes, from birth to less than 6 weeks <input type="checkbox"/> Yes, from birth to 6 weeks <input type="checkbox"/> Yes, from birth to 3 months <input type="checkbox"/> Yes, from birth to 6 months <input type="checkbox"/> Yes, from birth to 12 months <input type="checkbox"/> Yes, from birth to over 12 months <input type="checkbox"/> Still breast feeding <input type="checkbox"/> No, did not breast feed
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Did you get a free pack of books for your child (Bookstart pack)? (Please tick all that apply) <input type="checkbox"/> Yes, Bookstart pack 0 – 12 months <input type="checkbox"/> Yes, Bookstart pack 12 – 24 months <input type="checkbox"/> Yes, Bookstart Treasure Chest 2 – 3 years (given out by Early Years settings) <input type="checkbox"/> No, did not receive Bookstart pack
Child's weight at birth

Please give details of any other adult who is legal guardian, or who has parental responsibility, for this child (we may contact them for more information).

Name of Adult	
Date of Birth	
Address	
	Postcode

Telephone home	
Telephone mobile	
What is their relationship to this child? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Other (please specify)	

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Information about the child or children in your family (those you have parental responsibility for)

Please fill in one section for each child

THIRD CHILD

First name/s		Ethnicity (Please tick the appropriate box to indicate your child's ethnic group) A White <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> European <input type="checkbox"/> Gypsy/Roma <input type="checkbox"/> Traveller of Irish Heritage <input type="checkbox"/> Any Other White Background B Mixed/Dual Background <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Asian <input type="checkbox"/> Any Other Mixed Background C Asian or Asian British <input type="checkbox"/> Pakistani <input type="checkbox"/> Indian <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any Other Asian Background D Black or Black British <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other Black Background E Chinese or other ethnic group <input type="checkbox"/> Chinese <input type="checkbox"/> Other (please specify) <input type="checkbox"/> Prefer not to say
Middle name		
Surname		
What is your relationship to this child?	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Other (please specify)	
Date of birth		
National Health Number		
School child attends (if applicable)		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	

Do you consider your child to have a special need?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you consider your child to have a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child live at the same address as you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, what is their address?	
Postcode	

Are you, or did you, breast feed your child? (Please tick all that apply) <input type="checkbox"/> Yes, from birth to less than 6 weeks <input type="checkbox"/> Yes, from birth to 6 weeks <input type="checkbox"/> Yes, from birth to 3 months <input type="checkbox"/> Yes, from birth to 6 months <input type="checkbox"/> Yes, from birth to 12 months <input type="checkbox"/> Yes, from birth to over 12 months <input type="checkbox"/> Still breast feeding <input type="checkbox"/> No, did not breast feed
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Did you get a free pack of books for your child (Bookstart pack)? (Please tick all that apply) <input type="checkbox"/> Yes, Bookstart pack 0 – 12 months <input type="checkbox"/> Yes, Bookstart pack 12 – 24 months <input type="checkbox"/> Yes, Bookstart Treasure Chest 2 – 3 years (given out by Early Years settings) <input type="checkbox"/> No, did not receive Bookstart pack
Child's weight at birth

Please give details of any other adult who is legal guardian, or who has parental responsibility, for this child (we may contact them for more information).

Name of Adult	
Date of Birth	
Address	
	Postcode

Telephone home	
Telephone mobile	
What is their relationship to this child? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Other (please specify)	

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Information about the child or children in your family (those you have parental responsibility for)

Please fill in one section for each child

FOURTH CHILD

First name/s		Ethnicity (Please tick the appropriate box to indicate your child's ethnic group) A White <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> European <input type="checkbox"/> Gypsy/Roma <input type="checkbox"/> Traveller of Irish Heritage <input type="checkbox"/> Any Other White Background B Mixed/Dual Background <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Asian <input type="checkbox"/> Any Other Mixed Background C Asian or Asian British <input type="checkbox"/> Pakistani <input type="checkbox"/> Indian <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any Other Asian Background D Black or Black British <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other Black Background E Chinese or other ethnic group <input type="checkbox"/> Chinese <input type="checkbox"/> Other (please specify) <input type="checkbox"/> Prefer not to say
Middle name		
Surname		
What is your relationship to this child?	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Other (please specify)	
Date of birth		
National Health Number		
School child attends (if applicable)		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	

Do you consider your child to have a special need?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you consider your child to have a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child live at the same address as you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, what is their address?	
Postcode	

Are you, or did you, breast feed your child? (Please tick all that apply) <input type="checkbox"/> Yes, from birth to less than 6 weeks <input type="checkbox"/> Yes, from birth to 6 weeks <input type="checkbox"/> Yes, from birth to 3 months <input type="checkbox"/> Yes, from birth to 6 months <input type="checkbox"/> Yes, from birth to 12 months <input type="checkbox"/> Yes, from birth to over 12 months <input type="checkbox"/> Still breast feeding <input type="checkbox"/> No, did not breast feed
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Did you get a free pack of books for your child (Bookstart pack)? (Please tick all that apply) <input type="checkbox"/> Yes, Bookstart pack 0 – 12 months <input type="checkbox"/> Yes, Bookstart pack 12 – 24 months <input type="checkbox"/> Yes, Bookstart Treasure Chest 2 – 3 years (given out by Early Years settings) <input type="checkbox"/> No, did not receive Bookstart pack
Child's weight at birth

Please give details of any other adult who is legal guardian, or who has parental responsibility, for this child (we may contact them for more information).

Name of Adult	
Date of Birth	
Address	
	Postcode

Telephone home	
Telephone mobile	
What is their relationship to this child? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Other (please specify)	

I understand that if I am providing personal information for other people, it is my responsibility to inform them of this.