



FYLING HALL SCHOOL

Robin Hood's Bay

North Yorkshire

YO22 4QD

T: 01947 880353

E: office@fylinghall.org

W: www.fylinghall.org

Please return this form to the Headmaster with the registration fee of £100

ACCEPTANCE FORM

(please use block capitals)

PARENTAL INFORMATION

Name of parent(s) _____

Address _____

Telephone (home) _____

Telephone (work) _____

Mobile _____

Email _____

We/I hereby accept the offer of a place at the School for

Full name of pupil _____

Date of birth _____

with effect from _____ (date starting at the school)

We/I acknowledge and agree that the terms and conditions attached to this Form of Acceptance as varied from time to time form part of the contract between us/me and the School. In particular, we/I agree to pay the fees and supplemental charges when due.

We/I agree that we/I and our/my child shall observe and be bound by the School Rules, which are issued annually to all students and parents/guardians, as varied from time to time.

Signed by: _____

Parent/Guardian*

Date

Parent/Guardian*

Date

* Please delete as appropriate`

[NB: Except in the case of a single parent/guardian who has custody of the child, this Acceptance Form must be signed by both parents/guardians.]

ALTERNATIVE CONTACT

(in the event of an emergency)

Name _____

Address _____

Telephone (home) _____

Telephone (work) _____

Email _____

Relationship (if any) to pupil _____

PUPIL INFORMATION

(to be completed by the parent/guardian)

Particular dietary needs _____

Special Educational Needs (please provide a copy of any previous educational psychologist or other reports)

Present School _____

Address _____

Headteacher _____

The School requires full and detailed disclosure of the pupil's behavioural, mental and physical status prior to acceptance of the place. The offer of a place is made on the basis of this disclosure and, should such matters not be disclosed in full to the school, the school is entitled to treat the contract as null and void.



FYLING HALL SCHOOL

PUPIL HEALTH QUESTIONNAIRE

(please use block capitals)

PUPIL INFORMATION

Surname _____

Christian Names _____

Sex _____ Date of Birth _____

Place and Country of Birth _____

Name and address of previous Doctor _____

Please answer ALL of the following questions

Has your child ever suffered from

- | | | |
|------------------------------------|------------------------------|-----------------------------|
| a. Rheumatic fever | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. Heart complaint | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. Asthma or other lung conditions | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e. Hepatitis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f. Excessive bleeding | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| g. Bone problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| h. Arthritis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Is your child allergic to any medicines or tablets? If YES please specify

Is your child at present taking any medicines or tablets? If YES please specify

Has your child been treated with steroids in the past two years? Yes No

Has your child ever had a bad reaction to local or general anaesthetic? Yes No

Has your child had the following vaccinations? **Dates are very important – please complete if known**

Measles, Mumps & Rubella (MMR)

1st Dose Yes No Date _____

2nd Dose Yes No Date _____

Diphtheria, Whooping cough, Tetanus & Polio Yes No Date _____

Vaccinations Yes No Date _____

Pre School Booster Yes No Date _____

Any other vaccinations Yes No Date _____

Are there any other facts concerning your child's health, allergies or social circumstances you feel we should know about?

MEDICAL CONSENT

I agree that members of staff at Fyling Hall School may administer First Aid to the above child as necessary. I also recognise that at certain times the school may organise routine immunisations in accordance with schedules issued by the Department of Health (including an annual Flu vaccination if available), organised and overseen by Doctors at Whitby Group Practice. The above practice may update other vaccinations as necessary including:

Tetanus/Polio (every 10 years up to total of five)
Rubella (girls only) age 10 if no MMR

I have filled in a Children's Health Questionnaire and agree to notify the school of any significant changes to the information provided.

I also agree to my son/daughter receiving medication as instructed and any emergency dental, medical or surgical treatment, including anaesthetic or blood transfusion, as considered necessary by the medical authorities present.

Signed _____ Date _____

Name _____