

Holiday Camp Registration Form

Date of registration: _____

Please complete this form in a black pen using BLOCK CAPITALS.

CHILD'S DETAILS

| | | | | |
|----------------|------------------|----------|-----------------|-----------------|
| First name: | | Surname: | | Preferred name: |
| Date of birth: | School attended: | | First language: | |

PARENT/GUARDIAN 1

PARENT/GUARDIAN 2

| | | | | | |
|--|----------------|--------------|---|----------------|--------------|
| Title: | Full name: | | Title: | Full name: | |
| Home address: | | | Home address (if different): | | |
| Does this child normally live at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Does this child normally live at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Work address: | | | Work address: | | |
| Home number: | Mobile number: | Work number: | Home number: | Mobile number: | Work number: |
| Email: | | | Email: | | |
| Does this person have parental responsibility? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Does this person have parental responsibility? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Does anyone else have parental responsibility for this child? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please provide details on separate sheet.) | | | | | |

We'd love to keep you updated on the latest offers, news and information from Places for People Leisure Limited by email, post, SMS and phone. We'll always treat your personal details with the utmost care and will never provide them to other companies for marketing purposes. Please tick here if you would like to opt in:
 Parent/Guardian 1: ☐ Yes please, I'd like to hear about offers and services. Parent/Guardian 2: ☐ Yes please, I'd like to hear about offers and services.

EMERGENCY CONTACT (please provide details of who we can contact if we are unable to get hold of you)

| | | |
|----------|--------------|----------------------------|
| Name: | Home number: | Mobile number: |
| Address: | | Relationship to the child: |

CHILD'S DOCTOR

| | |
|-----------------|-------------------|
| Name of Doctor: | Telephone number: |
| Address: | |

ABOUT YOUR CHILD

| | | |
|---|---|-------------------------|
| Please detail any additional/special needs your child has: | | |
| Please detail any dietary requirements/food allergies for your child: | | |
| Health problems? | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | If yes, please specify: |
| Regular medications? | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | If yes, please specify: |

PLEASE IDENTIFY YOUR ETHNICITY BELOW (please tick)

| White | Black or Black British | Mixed | Asian or Asian British | Chinese, Or Other Ethnic Group |
|---|---|--|---|---|
| White British <input type="checkbox"/> | Caribbean <input type="checkbox"/> | White and Black Caribbean <input type="checkbox"/> | Indian <input type="checkbox"/> | Chinese <input type="checkbox"/> |
| White Irish <input type="checkbox"/> | African <input type="checkbox"/> | White and Black African <input type="checkbox"/> | Pakistani <input type="checkbox"/> | Any other ethnic group <input type="checkbox"/> |
| Any other white background <input type="checkbox"/> | Any other black background <input type="checkbox"/> | White and Asian <input type="checkbox"/> | Bangladeshi <input type="checkbox"/> | |
| Prefer not to say <input type="checkbox"/> | | | Any other Asian background <input type="checkbox"/> | |

| | | |
|--|-------------|-------|
| Signature of Applicant/Parent or Guardian: | Print name: | Date: |
|--|-------------|-------|

SIGNED ON BEHALF OF THE COMPANY

| | | |
|------------|-------------|-------|
| Signature: | Print name: | Date: |
|------------|-------------|-------|