



<b>REGISTRATION FORM</b>					<b>Family ID number</b>				
<b>Primary Carer</b>					<b>Secondary Carer</b>				
<i>(if it is the same information write same)</i>									
Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Ms <input type="checkbox"/>	Miss <input type="checkbox"/>	Other .....	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Ms <input type="checkbox"/>	Miss <input type="checkbox"/>	Other .....
<b>First Name</b>					<b>First Name</b>				
<b>Surname</b>					<b>Surname</b>				
<b>Date of Birth</b>					<b>Date of Birth</b>				
<b>Relationship to child:</b>					<b>Relationship to child:</b>				
<b>Gender</b>		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Trans <input type="checkbox"/> Other	<input type="checkbox"/> Prefer not to say	<b>Gender</b>		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Trans <input type="checkbox"/> Other	<input type="checkbox"/> Prefer not to say
<b>Home Address</b>					<b>Home Address</b>				
<b>Postcode</b>					<b>Postcode</b>				
<b>Home/Mobile Telephone No.</b>					<b>Home/Mobile Telephone No.</b>				
<b>Email Address</b>					<b>Email Address</b>				
<b>Health Visitor</b>					<b>Health Visitor</b>				
<b>Clinic/Centre</b>					<b>Clinic/Centre</b>				
<b>Are you expecting a baby?</b>					<b>Are you expecting a baby?</b>				
<input type="checkbox"/> Yes <input type="checkbox"/> No If, Yes the due date is? .....					<input type="checkbox"/> Yes <input type="checkbox"/> No If, Yes the due date is? .....				
<b>Are you a lone parent?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No			<b>Are you a lone parent?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Ethnicity</b> Please indicate which ethnic group you consider you belong to:		<input type="checkbox"/> White – British <input type="checkbox"/> Any other White background <input type="checkbox"/> Black- British <input type="checkbox"/> Any other Black background <input type="checkbox"/> Any Asian background <input type="checkbox"/> Any Mixed background <input type="checkbox"/> Any other Ethnic group <input type="checkbox"/> Traveller / Gypsy/Roma <input type="checkbox"/> Prefer not to say			<b>Ethnicity</b> Please indicate which ethnic group you consider you belong to:		<input type="checkbox"/> White – British <input type="checkbox"/> Any other White background <input type="checkbox"/> Black- British <input type="checkbox"/> Any other Black background <input type="checkbox"/> Any Asian background <input type="checkbox"/> Any Mixed background <input type="checkbox"/> Any other Ethnic group <input type="checkbox"/> Traveller / Gypsy/Roma <input type="checkbox"/> Prefer not to say		
<b>What language do you use at home?</b>					<b>What language do you use at home?</b>				
.....					.....				
<b>Do you consider you have a disability/ special need or medical condition?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No			<b>Do you consider you have a disability/ special need or medical condition?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>Details .....</i>		<i>Details .....</i>			<i>Details .....</i>		<i>Details .....</i>		
<i>I need the following adjustments</i>		<i>I need the following adjustments</i>			<i>I need the following adjustments</i>		<i>I need the following adjustments</i>		
.....		.....			.....		.....		

Child 1		Child 2	
<b>First Name</b>		<b>First Name</b>	
<b>Surname</b>		<b>Surname</b>	
<b>Date of Birth</b>		<b>Date of Birth</b>	
<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Ethnicity</b> Please indicate which ethnic group you consider you belong to	<input type="checkbox"/> White – British <input type="checkbox"/> Any other White background <input type="checkbox"/> Black- British <input type="checkbox"/> Any other Black background <input type="checkbox"/> Any Asian background <input type="checkbox"/> Any Mixed background <input type="checkbox"/> Any other Ethnic group <input type="checkbox"/> Traveller / Gypsy/Roma <input type="checkbox"/> Prefer not to say	<b>Ethnicity</b> Please indicate which ethnic group you consider you belong to	<input type="checkbox"/> White – British <input type="checkbox"/> Any other White background <input type="checkbox"/> Black- British <input type="checkbox"/> Any other Black background <input type="checkbox"/> Any Asian background <input type="checkbox"/> Any Mixed background <input type="checkbox"/> Any other Ethnic group <input type="checkbox"/> Traveller / Gypsy/Roma <input type="checkbox"/> Prefer not to say
<b>Do you consider your child has a disability/ special need or medical condition?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Details .....</i> <i>He/ she needs the following adjustments</i> .....	<b>Do you consider your child has a disability/ special need or medical condition?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Details .....</i> <i>He/ she needs the following adjustments</i> .....

Child 3		Child 4	
<b>First Name</b>		<b>First Name</b>	
<b>Surname</b>		<b>Surname</b>	
<b>Date of Birth</b>		<b>Date of Birth</b>	
<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Ethnicity</b> Please indicate which ethnic group you consider you belong to	<input type="checkbox"/> White – British <input type="checkbox"/> Any other White background <input type="checkbox"/> Black- British <input type="checkbox"/> Any other Black background <input type="checkbox"/> Any Asian background <input type="checkbox"/> Any Mixed background <input type="checkbox"/> Any other Ethnic group <input type="checkbox"/> Traveller / Gypsy/Roma <input type="checkbox"/> Prefer not to say	<b>Ethnicity</b> Please indicate which ethnic group you consider you belong to	<input type="checkbox"/> White – British <input type="checkbox"/> Any other White background <input type="checkbox"/> Black- British <input type="checkbox"/> Any other Black background <input type="checkbox"/> Any Asian background <input type="checkbox"/> Any Mixed background <input type="checkbox"/> Any other Ethnic group <input type="checkbox"/> Traveller / Gypsy/Roma <input type="checkbox"/> Prefer not to say
<b>Do you consider your child has a disability/ special need or medical condition?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Details .....</i> <i>He/ she needs the following adjustments</i> .....	<b>Do you consider your child has a disability/ special need or medical condition?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Details .....</i> <i>He/ she needs the following adjustments</i> .....

#### How we use your data

The information on this form will be stored securely by East Riding of Yorkshire Council and used to provide you with our services, keep you informed and for monitoring purposes. The information will be processed in accordance with the Data Protection Act 1998. Please also be aware that should any safeguarding concerns arise, information may be shared in order to protect the safety of the individuals concerned. This will only be done under the guidance of the local safeguarding children board and specialist teams.

#### Declaration

I understand that the information I have given about myself and any other individuals will be held and processed by East Riding of Yorkshire Council and it is my responsibility to make the other adults listed on this form aware that their details have been provided.

Carer 1		Carer 2	
<b>Signature</b>		<b>Signature</b>	
<b>Date</b>		<b>Date</b>	