



CHILD REGISTRATION FORM

Child's Name: _____ Date of Birth: _____

Parent/Guardian Names: _____ Child's Age: ____

Nationality: _____

Occupations: _____

Address: _____

Postcode: _____

Telephone No: _____

Religion: _____

Email: _____

Emergency Contact Number: _____

Doctor's Name & Address: _____

Dietary Requirements: _____

Any Allergies: Yes/No: _____

Medication: Yes/No: _____

Health problems/conditions Yes/No: _____

Preferred Date of Entry: _____

Sessions Required:
(Please tick)

*Minimum 2 full
days for babies

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

I agree to Twinkles Terms and Conditions

Parent 1 Signed: _____ Date: _____

Parent 2 Signed: _____ Date: _____