

LOMOND SCHOOL APPLICATION FORM

The information on this form is processed electronically for administrative purposes and is subject to the terms of the Data Protection Act 1998

PLEASE COMPLETE IN BLOCK CAPITALS

Forenames of Pupil			
Surname of Pupil			
Date of Birth			<i>Please give figures; e.g 16 6 84</i>
		Gender M/F	
Proposed date of admission and form class			
If Nursery please state which days	Mon <input type="checkbox"/>	Tues <input type="checkbox"/>	Wed <input type="checkbox"/>
	Thurs <input type="checkbox"/>	Fri <input type="checkbox"/>	<i>(please tick)</i>
Do you intend pupil to join Lomond Junior School on completion of Nursery ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>(please tick)</i>
Day pupil or boarder	<input type="checkbox"/> day	<input type="checkbox"/> boarder	<i>(please tick)</i>
Proposed subject choices (Pupils entering S3 or above)			
Names of brothers and sisters already at the school (if any)			
Pupils home address			
Post Code		Home tel. no.	
E-mail address			
Parents / Guardians living at pupil's home address (see overleaf)			
Relationship to pupil	<i>e.g. Father</i>	<i>e.g. Mother</i>	
Title			
Forenames			
Surname			
Can be contacted in an emergency during the day	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>(please tick)</i>
If yes give whereabouts (e.g. home or name of workplace)			
Daytime Tel No. / mobile			
Fees Notes / letters to be addressed to parents / guardians named above using pupil's address. If this is not appropriate, please write the alternative here			
Other emergency contacts (excluding parents / guardians)			
Previous School			

For Office use only

Parents Occupation	<i>Father</i>	<i>Mother</i>
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Medical Details

Doctor's full name		Tel No.	
Address			

In the best interests of the pupil, it is important to advise the School of any disability that the pupil has and of any medical condition or other circumstances which might require the pupil to be given special assistance at the School or which you think the School should be aware. Please give details here or in separate note letter to accompany this form.
The information is processed electronically but in coded form to enable staff to respond to pupil's needs.

Additional parental contacts / Guardian details

For the purposes of the School records, pupil's parent is defined as his/her natural parent and any other person who is his/her guardian, who has custody of, or who is likely to maintain him/her.

Please add below anyone who comes into this category but who is not shown overleaf.

Relationship to pupil <i>(e.g. Mother, Father or Grandparent)</i>		
Title		
Surname		
Can be contacted in an emergency during the day	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(please tick)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(please tick)</i>
If yes give whereabouts <i>(e.g. at home or name of workplace)</i>		
Daytime Tel No		
Address		
Postcode		
Home Tel No		

I/We, being the parent/parents of or being the person/persons having parental rights in respect of the pupil:

- hereby apply for a place at Lomond School for the pupil to become a pupil at the School with effect from the admission date specified above;
- attach a non-refundable £50 Registration Fee (£25 for Nursery applicants) is attached;
- accept that this is subject to the School's admissions policy current as at the date of receipt of this application by the School as such policy is from time to time revised or amended;
- recognise there is no obligation on the School to offer a place at the School for the pupil or to accept the pupil as a pupil at the School; and
- authorise the pupil's current school to (a) confirm to the School whether all fees in respect of the pupil have been paid to the current school and (b) disclose to the School information on the pupil (e.g. academic report and pupil profile), and authorise the School to disclose this application and authorisation to that current school.

Signed.....(Parent / Guardian) Name..... Date.....

Signed.....(Parent / Guardian) Name..... Date.....



LOMOND SCHOOL - HEALTH CARE

It is important that you return this questionnaire fully completed to the school as soon as possible.

Name: GP:

Previous address: GP address:

Postcode:

Class Year Town of birth:

DoB / CHI No. : County of birth:

NHS No. : Registered district of birth:

Gender: Mother's maiden name:

If returning from abroad:-

Date of departure from UK:

Date of return:

Your NHS Board has made arrangements for assessing and reviewing the health of children and young people throughout their school years in accordance with the NHS (Scotland) Act 1978 and the Education (Scotland) Act 1980. This is done to ensure all children and young people are provided with the necessary support to help towards achieving their full potential.

Please complete the following sections:

CONSENT

I consent to my child participating in the School Health Surveillance Programme.

Yes No (Please tick appropriate box)

Name of Parent/Carer (please print)

Signature of Parent/CarerDate

I consent to any medical information RELEVANT TO MY CHILD'S EDUCATION being shared with appropriate education staff.

Yes No (Please tick appropriate box)

Signature of Parent/CarerDate

HAVE YOU ANY CONCERNS ABOUT YOUR CHILD'S HEALTH?

General health

Growth and development

Weight

Behaviour

Learning difficulties

Number of children in the family

Place of child in the family

HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES/ACCIDENTS? Yes No

If **YES**, please give details
.....
.....

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING?

- | | | | | | |
|--|------------------------------|-----------------------------|---------------------------|------------------------------|-----------------------------|
| Severe allergy | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Problems with eyesight | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Severe epilepsy, convulsions, fainting turns | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Bed-wetting | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Problems with hearing | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Soiling | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Problems with speech | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Emotional problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Coordination/movement difficulties | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any other health problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If **YES**, please give details
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HAS YOUR CHILD COMPLIED WITH THE NHS CHILD IMMUNISATION PROGRAMME? Yes No

If **NO**, please give details
.....

HAS YOUR CHILD HAD CHICKENPOX? Yes No

IS YOUR CHILD CURRENTLY ATTENDING HOSPITAL/CLINIC? Yes No

If **YES**, please give details
.....

IS YOUR CHILD ON ANY TREATMENT/MEDICATION AT PRESENT? (including over the counter medicines) Yes No

If **YES**, please give details
.....

WOULD YOU LIKE AN OPPORTUNITY TO DISCUSS ANYTHING WITH THE SCHOOL NURSE?

Yes No

If **YES**, please give reason

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FOR BOARDING PUPILS ONLY

HAS YOUR CHILD BEEN SEEN BY A DENTIST IN THE LAST 12 MONTHS? Yes No

DOES YOUR CHILD HAVE BRACES? Yes No

DO YOU WISH YOUR CHILD TO BE INCLUDED IN THE SCHOOL DENTAL PROGRAMME (INCLUDING X-RAYS)? Yes No

HAS YOUR CHILD HAD THEIR EYES TESTED IN THE LAST 12 MONTHS? Yes No

DOES YOUR CHILD WEAR GLASSES/CONTACT LENSES? Yes No

DO YOU WISH YOUR CHILD TO HAVE THEIR EYES TESTED USING THE SCHOOL OPTICIAN? Yes No

IF YOUR CHILD IS A GIRL

Have periods started? Don't know Yes No

If YES: Age periods started

Any problems with periods? Yes No

If **YES**, please describe

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PLEASE CONTACT THE SCHOOL NURSE ON **01436 672476** IF YOU REQUIRE MORE INFORMATION.

THANK YOU FOR TAKING THE TIME TO COMPLETE THE QUESTIONNAIRE.
HAVE YOU REMEMBERED TO SIGN THE CONSENT BOX?
The information you have given will be treated in the strictest confidence.