Little Coconuts Early Learning Center Co, Ltd
157 / 53 Moo 1
Thambon Bophut, Koh Samui
Suratthani, Thailand, 84320

Details of child **Date of enrolment** _______ / _________ / _________

Family name _________________________ Given names __________________________________

Nick name _______________________________ Date of birth ______ / _______ / ______ sex **M / F**

Child's nationality ________________________________ Entering year level ____________________

Languages spoken at home ____

Residing with: Mother Father Both Guardian

Are there any custody arrangements the nursery should be aware of? Y / N

If yes please describe ____

Please give details of any previous education including name of school, year level, in which country and which languages were used in the nursery.

____

____

Details of parents

Father / Guardian's contact details

Family name _________________________ Given names __________________________________

Address ____

Home phone ______________________ Mobiles ____________________ Work __________________

Occupation ________________________________ Email _________________________________

Mother / Guardian's contact details

Family name ___________________________ Given names __________________________________

Address ____

Home phone _____________________ Mobiles ____________________ Work __________________

Occupation ________________________________ Email ____________________________________

Emergency contact (person other than parents or guardian)

Name ________________________________ Contact number __________________________

Relationship to Child ____

ENGLISH AS AN ADDITIONAL LANGUAGE

If you anticipate your child will need extra support in English, Please fill in the boxes below

How would you describe your child's level of English in the following areas

Understanding	☐ **None**	☐ **Basic**	☐ **Intermediate**	☐ **Advance**	☐ **Fluent**
Speaking	☐ **None**	☐ **Basic**	☐ **Intermediate**	☐ **Advance**	☐ **Fluent**
Reading	☐ **None**	☐ **Basic**	☐ **Intermediate**	☐ **Advance**	☐ **Fluent**
Writing	☐ **None**	☐ **Basic**	☐ **Intermediate**	☐ **Advance**	☐ **Fluent**

Please give any further details of EAL needs you feel your child might have

Child's details

Child's name____ Sex M / F

Age __________ Years ________ Months __________

Family Doctor _________________________ Phone ______________________________

Please answer the following questions as accurately as possible

1. Does your child have any special health needs or problems that the nursery should know about? Y / N Details ____
2. Has your child been diagnosed with any special education needs (e.g. ADHD, Asperger's Dyslexia) Y / N Details ____
3. Does your child take any medication on a regular basis? Y / N

   Details ____
4. What medications? ____
5. Do they need to take it during school hours? _______________________________ Y / N

6. Is your child going to a hospital clinic or doctor for ongoing treatment now? Y / N

7. Why? ____

8. Has your child ever had any serious illness, broken bones or surgery? Y / N

   Details ____

9. Has your child had any convulsions (fits, Seizures) in the last year? Y / N

Type of seizure _________________ How many ________ Date of last seizure _______________

10. Does your child have any special dietary requirements? (Please circle) Y / N
    Vegetarian Vegan Diary –free Gluten – free other (please specify)

Details ____

11. Does your child have a dentist? Y / N

    Name ________________________________ Date of last visit _________________________

12. Please indicate any of the following illnesses that your child has had.

    1. Measles Y / N 2. German measles Y / N 3. Mumps Y / N 4. Chicken pox Y / N

    5. Pneumonia Y / N 6. Dengue Y / N 7. Whooping cough Y / N

    8. Hand, foot and mouth Y / N 9. Malaria Y / N

13. Does your child have problems with any of the following (Please circle)
    Wheezing /shortness of breath Fainting Headaches vision hearing nosebleeds throat infections diarrhea coughs / colds stomach aches vomiting eczema rashes swollen joints sleeping circulation / blood
    Please give details ____

14. Does your child eat regular meals Y / N

15. What time does your child go to bed? ____

16. Are your child's vaccinations up to date Y / N Not sure

17. Put a circle around any of the following that concern you about your child.
    (Foundation stage to year 3 only)

Bedwetting   wetting during the day   thumb sucking   stuttering easily upset   shy   attention seeking   separation anxiety   day dreaming   nightmares   temper tantrums   stubborn or contrary   disobedience   lying   selfish/unable to share   sibling jealousy   fighting with other children   purposely destroying things   eating habits   other

Please give details ____

In the event of a minor accident or mild illness, do you consent to the following treatment to be administered to your child?

Basic first aid (including use of iodine ointment and dressings)   Y / N

Fever medication (paracetamol)   Y / N

In the event of a more serious accident or illness, I would like my child to be treated at the following medical facility:

(Name of hospital)____

I certify that the information given on this form is true and correct.

Signed ________________________________ Print ______________________________________

Relationship to child ____

Date _______ / ________ / __________

Little Coconuts Early Learning Center Co, Ltd

157 / 53 Moo 1,Thambon Bophut

Koh Samui, Suratthani, Thailand, 84320

Tel: + 66 (0)89 589 6356   www.littlecoconutsdaycare.com

Facebook: Little Coconuts Early Learning Center