

Form 1: Child/Young Person and Family Core Information

Child/young person's Name	
Date of Birth	
Estimated Date of Delivery	
CHI Number	
Unique Pupil/SCN	
Date Information Updated	

For school enrolment please also complete Form 1A

1. Personal Details

First Name(s)	.....	Surname	.....
Other Name(s)	.....	Known as	.....
Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>	Ethnicity	.....
Nationality	.....	Language Spoken at home	.....
Place of Birth	.....	Religion	.....

Current Address	Postcode	Telephone/Email	Whose Address is this
			<input type="checkbox"/> Parental home <input type="checkbox"/> Foster placement <input type="checkbox"/> Residential school <input type="checkbox"/> Residential care <input type="checkbox"/> With relatives <input type="checkbox"/> Other (please specify)

Emergency Contact Person

Name	Relationship	Contact Telephone Numbers	Email Address

Is any information regarding the child/young person to be withheld: Yes ☐ No ☐

IF YES, PLEASE COMPLETE FORM 8

Previous Address (most recent first)

From	To	Address	Postcode	Telephone	Whose Address is this
					<input type="checkbox"/> Parental home <input type="checkbox"/> Foster placement <input type="checkbox"/> Residential school <input type="checkbox"/> Residential care <input type="checkbox"/> With relatives <input type="checkbox"/> Other (please specify)
					<input type="checkbox"/> Parental home <input type="checkbox"/> Foster placement <input type="checkbox"/> Residential school <input type="checkbox"/> Residential care <input type="checkbox"/> With relatives <input type="checkbox"/> Other (please specify)
					<input type="checkbox"/> Parental home <input type="checkbox"/> Foster placement <input type="checkbox"/> Residential school <input type="checkbox"/> Residential care <input type="checkbox"/> With relatives <input type="checkbox"/> Other (please specify)

Parents' Details

Names	Date of Birth (or CHI)	Address/Telephone Number/Email	Parental Rights?	If the child/young person does not live with this parent how often do they see them?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	
			Yes <input type="checkbox"/> No <input type="checkbox"/>	
			Yes <input type="checkbox"/> No <input type="checkbox"/>	

If birth parents do not hold parental rights please specify who does: _____

2. Members of the Child/Young Person's Household

Forename	Surname	DOB (or CHI)	Gender Male/ Female	Place in Family/ Relationship	Employment Status/ School

3. Other Relevant People

Name	Date of Birth	Relationship	Address and/or Contact Telephone Numbers

4. Named Person

Name of Professional	Contact Details	Agency	Start Date	End Date

5. Health Details

Name of Professional	Address	Telephone	Email Address	Dates
Named Health Visitor:				
GP Name:				
Other:				
Other:				
Other:				

Does the child/young person have a disability:

Yes ☐ No ☐

6. Accessibility and Communication Requirements

Are there accessibility and/or communication requirements for the child/young person:

☐ Yes ☐ No

If yes, the child/young person requires the following:

Are there accessibility and/or communication requirements for the parent(s) or carer(s):

☐ Yes ☐ No

If yes, the parent or carer requires the following:

7. Education Details

Current Establishment	Stage/Year	Start Date	%Session Attendance	Staged Intervention Level

Additional Support Needs

Yes ☐ No ☐

Additional support concerns (please tick all applicable):

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Deaf blind |
| <input type="checkbox"/> Autistic Spectrum disorder | <input type="checkbox"/> Physical or motor impairment |
| <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Physical health problem |
| <input type="checkbox"/> Multiple disabilities | <input type="checkbox"/> Social, emotional and behavioural difficulty |
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Mental health problem |
| <input type="checkbox"/> Other specific learning difficulty (eg numeric) | <input type="checkbox"/> Interrupted learning |
| <input type="checkbox"/> Other moderate learning difficulty | <input type="checkbox"/> Young carer |
| <input type="checkbox"/> Language/speech or communication disorder | <input type="checkbox"/> Looked after |
| <input type="checkbox"/> Communication support needs | <input type="checkbox"/> English as an additional language |
| <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> More able pupil |
| <input type="checkbox"/> Visual impairment | <input type="checkbox"/> Other (please specify) _____ |

Child/Young Person's Action Plan in place

Yes ☐ No ☐

Co-ordinated Support Plan in place

Yes ☐ No ☐

Previous Educational Establishments (if known)

Establishment	Address	Start Date	End Date	Summary of Involvement or Intervention

8. Other Professionals and Agencies/Services Involved with Child/Young Person and Family

Professional and Agency/Service	Who are they involved with	Contact Details

9. Child Protection

Concerns

Currently

☐ Yes

☐ No

Previously

☐ Yes

☐ No

Registration

Currently

☐ Yes

☐ No

Previously

☐ Yes

☐ No

If yes, please provide details:

10. Asylum Status

Child/Young Person

Not Applicable <input type="checkbox"/>	Asylum Seeker <input type="checkbox"/>	Refugee <input type="checkbox"/>
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Main Carer

Not Applicable <input type="checkbox"/>	Asylum Seeker <input type="checkbox"/>	Refugee <input type="checkbox"/>
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11. Legal Orders

Are there any Legal Orders in place

☐ Yes

☐ No

If yes, please provide details:

12. Name and Contact Details of person(s) completing form:

Name	Designation	Contact Details	Date

13. Signature:

Date:

Pupil Enrolment Form 1A (Primary and Secondary)

Please also complete Form 1

Pupil Forename(s)		Pupil Surname	
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Name of School	
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Details of siblings at this school?

(If your child has siblings at this school please fill in the following table for each child)

	Surname	Forename(s)	DOB	Sex	Year Group
1					
2					
3					

Declaration

I declare the information on this form and Child's Plan Form 1A to be correct to the best of my knowledge and that the address I have given for the child/young person is the address at which they are ordinarily resident. The child/young person lives at this address with me and I am the parent/carer/legal guardian. The address I have given is not the address of a friend, relative, business or any other type of address. I agree that the information I have given on this form may be checked with any of the following: previous nurseries and schools, my child's GP, Council Tax Records, the Electoral Roll, Housing Services.

Signed: _____ **Date:** _____
Parent/Carer/Legal Guardian

Information Sharing

A key part of identifying a child or young person's needs is collecting and sharing relevant information with services and agencies who have knowledge of that child or young person, including Scottish Qualification Authority and the Scottish Government.

Across Forth Valley, the following services/agencies may be involved in this process: Education, Social Work and other Council Services; Police Scotland; the National Health Service; Voluntary Organisations; Scottish Children's Report Administration (SCRA); Other organisations providing a service to children, young people and families.

Parent/Carer/Guardian Consent

I consent to relevant information being shared between services/agencies in order to identify appropriate supports to meet the child/young person's needs. I have had the reasons for information sharing with other services/agencies explained to me and I understand those reasons.

Signed: _____ **Date:** _____
Parent/Carer/Legal Guardian

Please Tick All Medical Conditions Under Column A & Number In Order Of Medical Severity, ie 1, 2 Etc In Column B Where 1 Is The Most Severe Medical Condition

	A	B		A	B		A	B		A	B
Abscess	<input type="checkbox"/>	<input type="checkbox"/>	Bowel - Problem	<input type="checkbox"/>	<input type="checkbox"/>	Heart - Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Phenylketonuria	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Bowel - Stoma	<input type="checkbox"/>	<input type="checkbox"/>	Heart - Other	<input type="checkbox"/>	<input type="checkbox"/>	Physical Disability	<input type="checkbox"/>	<input type="checkbox"/>
Albanism	<input type="checkbox"/>	<input type="checkbox"/>	Brain Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Heart - Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Physical/Motor Skills Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Allergy - Animal Hair	<input type="checkbox"/>	<input type="checkbox"/>	Brain Tumour	<input type="checkbox"/>	<input type="checkbox"/>	Heart - Periventricular Luokomalacia	<input type="checkbox"/>	<input type="checkbox"/>	Post Traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Allergy - Bananas	<input type="checkbox"/>	<input type="checkbox"/>	Bronchiectasis - Lung condition	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Prader-Willi Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Allergy - Citrus	<input type="checkbox"/>	<input type="checkbox"/>	Bronchmalasia	<input type="checkbox"/>	<input type="checkbox"/>	Heart condition - coortation of the aorta	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Stenosis	<input type="checkbox"/>	<input type="checkbox"/>
Allergy - Dust Mites	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Valve Stenosis	<input type="checkbox"/>	<input type="checkbox"/>
Allergy - 'E' Colourings	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Heart Operations	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Vein Abnormality	<input type="checkbox"/>	<input type="checkbox"/>
Allergy - Eggs	<input type="checkbox"/>	<input type="checkbox"/>	Coeliac Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problem - Aortic Stenosis	<input type="checkbox"/>	<input type="checkbox"/>	Raynauds Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Allergy - Face Paint	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problem – Hole in the Heart	<input type="checkbox"/>	<input type="checkbox"/>	Reflex Anoxic Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Allergy - Latex	<input type="checkbox"/>	<input type="checkbox"/>	Conduct Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problem - Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems/Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Allergy - Nut	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Adrenal Hyperplasia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problem - SVT	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever (Sydenhams Chorea)	<input type="checkbox"/>	<input type="checkbox"/>
Allergy - Other	<input type="checkbox"/>	<input type="checkbox"/>	Crohns Disease	<input type="checkbox"/>	<input type="checkbox"/>	Henoch-Scholein Purpura	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Allergy - Paracetamol	<input type="checkbox"/>	<input type="checkbox"/>	Croup	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Sever's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Allergy - Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	Hypermobility	<input type="checkbox"/>	<input type="checkbox"/>	Skeletal Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Allergy - Plasters	<input type="checkbox"/>	<input type="checkbox"/>	Dental	<input type="checkbox"/>	<input type="checkbox"/>	Impaired Mobility	<input type="checkbox"/>	<input type="checkbox"/>	Skeletal Dysplasia	<input type="checkbox"/>	<input type="checkbox"/>
Allergy - Shellfish	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problem	<input type="checkbox"/>	<input type="checkbox"/>	Skin Complaint - Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Allergy - Strawberries	<input type="checkbox"/>	<input type="checkbox"/>	Development Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Lactose Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Skin Complaint - Other	<input type="checkbox"/>	<input type="checkbox"/>
Allergy - Wasp/Bee Sting	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Leukaemia	<input type="checkbox"/>	<input type="checkbox"/>	Skin Complaint - Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Allergy - Wheat	<input type="checkbox"/>	<input type="checkbox"/>	Dispraxia	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problem	<input type="checkbox"/>	<input type="checkbox"/>	Speech Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Alopecia	<input type="checkbox"/>	<input type="checkbox"/>	Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoblastic Leukaemia	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylactic Shock	<input type="checkbox"/>	<input type="checkbox"/>	Dyslexia	<input type="checkbox"/>	<input type="checkbox"/>	Metabolic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Sprengels Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Dyspraxia	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis (MS)	<input type="checkbox"/>	<input type="checkbox"/>	Swallowing difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Asperger's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Muscular-Other	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Febrile Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	Friedrichs Ataxia	<input type="checkbox"/>	<input type="checkbox"/>	Ocular Albinism	<input type="checkbox"/>	<input type="checkbox"/>	Tourettes Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Autistic Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Funnelled Windpipe	<input type="checkbox"/>	<input type="checkbox"/>	ODD	<input type="checkbox"/>	<input type="checkbox"/>	Travel Sickness	<input type="checkbox"/>	<input type="checkbox"/>
Axonal Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	Gastric Problem	<input type="checkbox"/>	<input type="checkbox"/>	Oesophageal Atresia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Problem	<input type="checkbox"/>	<input type="checkbox"/>	Genetic Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Osgood Schlatters Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Urticaira - Skin condition	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder - Haemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Glue Ear	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Vegetarian / Vegan	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder - HIV	<input type="checkbox"/>	<input type="checkbox"/>	Gluten Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Pain-General	<input type="checkbox"/>	<input type="checkbox"/>	Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder - Other	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	Vomitting Phobia	<input type="checkbox"/>	<input type="checkbox"/>
Bowel - Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>	Perthes Disease	<input type="checkbox"/>	<input type="checkbox"/>	Walking Problem	<input type="checkbox"/>	<input type="checkbox"/>

Please sign & provide additional details relative to medical condition & current GP

Parent/Carer Signature: GP Surgery (Name & Address)

PARENTAL CONSENT FORM (Please complete all sections and sign where indicated)

Internet/E-Mail Acceptable Use Policy

As a pupil at this school, I agree to keep to the rules on internet/e-mail access as laid down in the Council Policy (Secondary Pupils only). Yes ☐ No ☐

As the parent/legal guardian of the pupil named below, I agree to ensure that they will use the Internet access provided by Council appropriately. Yes ☐ No ☐

Educational Excursion

I give permission for the child/young person to take part in any excursion and activities organised by this school or Education Services. Typical examples of activities (while not exhaustive) would include local visitor attractions, outdoor activities, swimming, community events, sporting activities, etc. Yes ☐ No ☐

Photography/Video Permission (Please only tick one box for each of the following)

I agree to allow the child/young person to be photographed or video-recorded in connection with all classroom and other school activities. These photographs/videos may be used for school publicity: in newsletters, displays and on the internet, including school social media sites. (The copyright in such photographs belongs to the photographer involved and not the school or the Council) Yes ☐ No ☐

Young Scot National Entitlement Card (Primary 7 and secondary school stage only)

I agree to allow the child/young person to be photographed for the purposes of issuing the Young Scot Card, for use as library and leisure card plus proof of age card. Yes ☐ No ☐

Closed Circuit Television (CCTV)

I understand schools and buses (used for school transport) use CCTV to aid with the prevention of crime and improvement of public safety. In the event of there having been an incident at the school or on a bus in which the child/young person was travelling, any CCTV footage taken of the incident (which might include film of the child/young person) may be viewed by senior management of the school in order to identify those involved and take appropriate action.

Behavioural Agreement/Dress Code

In order to maintain standards within our school we ask that parents/carers encourage their child/young person to comply with a minimum standard of behaviour both when in school and when travelling to and from school. We would also ask parents/carers to support the school dress code.

Signed: _____
Pupil (where appropriate)

Date: _____

Signed: _____
Parent/Guardian

Date: _____

Proof of residence in the school catchment area at enrolment was:

(Please take photocopy eg driving licence, council tax book, rent book, Child Benefit address)

Checked and signed by: _____
(Member of Staff)

Admission Date		Roll No	
Register Class		Placing Request	
Free Meals		Free Transport	
Scottish Candidate No		Unique Pupil No	

Pupil Curriculum (For secondary schools only)

First Year		Class		Set	
Second Year		Class		Set	

Year	Class	1	2	3	4	5	6	7	8	9
S3										
S4										
S5										
S6										