**Twilight One Off Booking Form**

Name of First Child: Class:

Name of Second Child: Class:

Name of Third Child: Class:

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please circle choices below to indicate your requirements | | | | | | | | | | **Twilight Use Only** | |
| Sessions | 1st Child | | | 2nd Child | | | 3rd Child | | | **Confirm Place Offered** | **Waiting List Required** |
| **CODE** |  | | |  | | |  | | |
| Monday | A | B | C | A | B | C | A | B | C |  |  |
| Tuesday | A | B | C | A | B | C | A | B | C |  |  |
| Wednesday | A | B | C | A | B | C | A | B | C |  |  |
| Thursday | A | B | C | A | B | C | A | B | C |  |  |
| Friday | A | B | C | A | B | C | A | B | C |  |  |

A = 3.30pm-430pm + snack £4

B = 4.30pm-6pm + meal £5

C = 3.30pm-6pm + meal £7

Requested Date(s):

Email:

I would like sibling discount 10%

I attach full payment of £

I consent to my child being photographed by Twilight staff for display in school and on the school website. YES NO (please delete as necessary)

I consent to my child watching U Certificate films should they attend a Twilight session, which involves a Film Night event. YES NO (please delete as necessary)

Email:

Signed: Date:

|  |  |
| --- | --- |
| Home Address: | |
| Name of parent/carer 1:  Mobile Number:  Work Number: | Relationship to Child: |
| Name of parent/carer 2:  Mobile Number:  Work Number: | Relationship to Child: |
| **Password to be used when alternative adult collecting your child** |  |

**Medical Information**

|  |
| --- |
| Doctor’s Name:  Doctor’s Phone Number:  Doctor’s Address: |
| Any special dietary requirements or food allergies: |
| Medical history, including any childhood illness which may affect daily care, e.g. asthma, allergies etc. |
| If your child has specific medical needs, e.g. an EpiPen or other medicine, please list them here and provide Twilight with all medicines needed. |

In the event of illness or any accident that occurs, I consent to any emergency medical treatment necessary during the time at Twilight. I authorise school staff to sign any written form of consent required by hospital staff or a doctor called to the site if the delay in getting my signature will endanger my child’s health and safety in any way. YES NO (please delete as necessary)

Signed: Date:

**By signing this document, I understand and agree to the terms as laid out in the Handbook**

Signed Parent: Date:

Signed Play Leader: Date: