Services Registration

**Family Details**

|  |
| --- |
| **Name of Client:**  |
| **One week Recurring 4 weeks** |
| **Youngest Child’s age : Boy/Girl N/A** |
| **Siblings Age:****Child 2: Child 3: Child 4:** |
|  **Adults in household:**  |
|  |

|  |
| --- |
| **Household: Any allergies or preferences? Yes/ No If yes please state** |
|  |
|  |
| **Status, please tick**  |
| Universal Credit |
| Low Income |
| No recourse to public Funds |
| **Religion** |
| **Telephone Number** |
| **Address for delivery:** |
|  |
|  |
| **Postcode :** |
|  |
| **Email:** |
| **Comments:** |

**Signed** …………………………………………… **Consent**……………………………….

Parent/ Guardian/ Referring agent

**Agent Contact Details……………………………………………………………………………………………………….**

**Office use**

|  |  |
| --- | --- |
| **Contact of referring agent** |  |
| **Company/Agent** |  |
| **Date:** |  |

**Please note: This registration is for the purpose of Guiding Hands Organisation CIC ONLY**