

St Sebastian’s Field of Dreams Day Nursery

Holly Road, Liverpool, L7 0LH

Telephone No: 0151 264 89 45

Date of Application………………………………………………………

Full Name of Child……………………………………………………………………………………………………………..

Date of Birth………………………………………………………………………………………………………………………

First Language……………………………………………………………………………………………………………………

Gender - Please circle - Female or Male . About My Child: (please provide any important information about your child’s and his/her needs:……………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………..

Name Parent/Carer………………………………….. Relationship to Child…………………………………..

D.O.B…………………………………………………….... Ethnicity………………………………………………………

Address…………………………………………………………………………………………………………………………..

Telephone…………………………………………………. Email………………………………………………………….

National Insurance Number…………………………………………………………………………………………..

Name Parent/Carer………………………………….. Relationship to Child…………………………………..

D.O.B……………………………………………………….. Ethnicity……………………………………………………..

Address…………………………………………………………………………………………………………………………..

Telephone…………………………………………………… Email………………………………………………………..

National Insurance Number………………………………………………………………………………………….. I / we wish to apply for a place \*as soon as possible\*.

From……………………………………………………………………(date)

The Nursery will be open from 7.45am to 5.45pm – Monday to FridayPlease requirements. Please circle the sessions that you require:

7.45am - 5.45pm Full Day Care Monday Tuesday Wednesday Thursday Friday

7.45am -12.45pm Morning Sessions Monday Tuesday Wednesday Thursday Friday

12.45pm - 5.45pm Afternoon Sessions Monday Tuesday Wednesday Thursday Friday

Signature Parent/Carer……………………………………………… ……………………………………………………

**Please turn over for 2 year old funding and 3 year old funding**

**2 Year Old Funding**

Name Parent / Carer………………………………………………………………….

D.O.B (Parent/Carer)..………………………………………………………………………………

National Insurance Number………………………………………………………………..

8.30am to 11.30am Morning session

12.45pm to 3.45pm Afternoon session

Please circle:- Morning session Afternoon session

Seen Prove of eligibility:- Yes or No Date seen:-………………………………

|  |  |  |  |
| --- | --- | --- | --- |
| **Day** | **AM** | **PM** | **Full Day** |
| **Monday** |  |  |  |
| **Tuesday** |  |  |  |
| **Wednesday** |  |  |  |
| **Thursday** |  |  |  |
| **Friday** |  |  |  |

**3 Year Old Funding**

Please circle:-

38 weeks of the year (Term time only) or 51 weeks of the year.

Name Parent / Carer…………………………………………………………………………………….

D.O.B (Parent/Carer)..………………………………………………………………………………….

National Insurance Number…………………………………………………………………………

Code…………………………………………………………………………………………………………….

Date:-……………………………………………………………..