



LITTLE KINGFISHERS

REGISTRATION FORM

I _____ (full name), understand that I must stay & participate with my child/children for the full duration of the Loganholme State School Little Kingfishers Program whilst being fully responsible for my child/children's welfare & care.

I fully agree and accept this as my responsibility at all times.

Signature _____ Date: __/__/____

WE THANK YOU FOR UNDERSTANDING

The Little Kingfishers Program aims to support you and your child/children through play.

We thank you and your child/children for joining us in our fun program
and we welcome you to the Loganholme State School community.



Program Co-Ordinator – MONIQUE GRAHAM Deputy Principal

Parent / Carers Details

Title : Ms Miss Mrs Mr

Full Name : _____

Home Address : _____

Telephone : Home _____ Mobile : _____

Email Address : _____

EMERGENCY CONTACT NAME : _____

EMERGENCY CONTACT TELEPHONE : _____

EMERGENCY CONTACT relationship to you : _____

EMERGENCY CONTACT relationship to child : _____

Children already attending our school : _____

Children attending Little Kingfishers :

CHILD # 1 Full Name : _____

D.O.B. : __/__/____ Interests : _____

Medical Conditions (incl. allergies) _____

Please outline treatment if required : _____

CHILD # 2 Full Name : _____

D.O.B. : __/__/____ Interests : _____

Medical Conditions (incl. allergies) _____

Please outline treatment if required : _____

CHILD # 3 Full Name : _____

D.O.B. : __/__/____ Interests : _____

Medical Conditions (incl. allergies) _____

Please outline treatment if required : _____