



## **Holy Trinity Lamorbey CE Primary School Reception Application**

Please read the School Information Booklet, as this will help you to provide the information requested in this booklet.

**Pupil Name:**

### **Mission Statement**

HTL transforms lives and builds futures through love, courage and wisdom. A strong standards agenda and ambitious broader curriculum offer ensures our pupils leave us exceptionally well prepared for life, in the knowledge that they are loved by God and that he has a unique purpose for each of them.

<b>Surname:</b>		<b>First Name(s):</b>	
<b>Chosen Name:</b>		<b>Date of Birth:</b>	
<b>Child's Home Address</b>		<b>Name &amp; address of last School/Nursery attended</b>	
<b>Home Tel:</b>		<b>Gender</b>	<input type="checkbox"/> M <input type="checkbox"/> F
<b>Names of brothers/sisters already attending HTL</b>			
<b>Child's position in family:</b>	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup> <input type="checkbox"/> 4 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> <input type="checkbox"/> 6 <sup>th</sup> <input type="checkbox"/> 7 <sup>th</sup>		
<b>Laterality:</b>	<b>Uses predominantly:</b> <input type="checkbox"/> Right hand <input type="checkbox"/> Left hand		

**Details of Parents/Guardians who live with the child**

	<b>Parent 1</b>	<b>Parent 2</b>
<b>Title:</b>		
<b>Surname:</b>		
<b>First Name:</b>		
<b>Relationship to child:</b>		
<b>Mobile No:</b>		
<b>Occupation:</b>		
<b>E-mail Address:</b>		

**Details of Parent/Guardian not living with the child**

<b>Title:</b>	
<b>Surname:</b>	
<b>First Name:</b>	
<b>Address:</b>	
<b>Mobile No:</b>	
<b>Occupation:</b>	
<b>E-mail Address:</b>	

<b>Please give details of any pertinent custody arrangements in place for this child</b>	
<b>Name &amp; address of last School/Nursery attended</b>	

<b>GP Name &amp; Address:</b>	
<b>Any known allergies:</b>	
<b>Regular medication:</b>	
<b>Any particular physical/health problems which might limit normal play activities:</b>	

**Any other referral:**

**Initial Assessment for Classroom Teacher (Please tick as appropriate)**

<b>Dexterity and Self Help</b>	<b>Parents' Advice</b>			<b>School Assessment</b>
	<b>With Ease</b>	<b>With Help</b>	<b>Unable</b>	
Can dress/undress Buttons/Laces Toilet alone Use of cutlery Can resolve simple puzzles Can hop Can throw a ball Can hold pencil correctly Can write name Can cut with scissors Can paint with brush				
<b>Social Development</b>	<b>Yes</b>	<b>No</b>	<b>Developing</b>	
Plays alongside other children Plays cooperatively with others (taking turns and sharing) Prefers to play alone Uses imagination to extend play Engages in verbal interaction				
<b>Knowledge and Recall</b>	<b>Yes</b>	<b>No</b>	<b>Developing</b>	
Knows: Name Age Address Basic colours Numbers to 10 Days of the week Can match real objects Can make comparisons e.g. more, less Can do simple addition of single numbers And simple subtraction of single numbers Can differentiate by weight				
<b>Language and Reading Readiness</b>	<b>Yes</b>	<b>No</b>	<b>Developing</b>	
Speaks in sentences Can describe objects Engages in conversation Initiates conversation e.g. questions Listens to others Replies to direct questions Can sit still and listen for a period of time Understands and obeys instructions Understands stories Joins in traditional rhymes				

Can retell a simple story Demonstrates book knowledge by: Holding/Finding beginnings Turning pages/showing interest				
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**Your child's favourite story or poem**

**Your child's favourite occupations**

**If your child likes to draw please let him/her draw something in the space below**

**Please provide any family or other details which the teacher might need to know and any information which you feel could help us to know and understand your child.**

(Please acquaint us with information or change of circumstances as they arise).

## Making Schools Better Places for Learning

Please help us to find out about any physical or mental health condition, impairment or difficulty that might affect your child's learning. We have a legal duty to take steps to improve outcomes for disabled people. The Department for Children, Schools and Families has developed a number of questions to help schools to obtain relevant information from all parents. The information will be used by us to promote the well-being of disabled children and to address any difficulties they face in all aspects of school life.

We will treat what you have told us here sensitively and in line with Data Protection laws. Our Privacy Notice is available on our website. None of the information will be shared with other parents or pupils.

### 1. Is your child affected as a result of a physical or mental health condition, impairment or difficulty? Please tick any that apply to your child.

Mobility; getting around in or outside the home	
Hand function: holding and touching	
Personal care: has difficulty washing, going to the toilet, dressing	
Eating & drinking: has difficulty eating or drinking by themselves, sickness or loss of appetite	
Incontinence: has difficulty controlling the passage of urine and/or faeces	
Communication: speaking and/or understanding others	
Learning; has special educational needs	
Hearing:	
Vision:	
Behaviour: has a condition that leads to the child being hyperactive or having a short attention span, or getting frustrated or behaving in a socially unacceptable manner	
Unconsciousness: has fits or seizures	
Diagnosed with Autism, Asperger Syndrome or Autistic Spectrum Disorder (ASD):	
Palliative care needs:	
Mental health needs e.g. depression, anxiety:	
Other (please provide information of any other area(s) that affect your child):	

### 2. Has your child seen a professional (e.g. paediatrician, psychologist) because of a physical or mental condition, impairment or difficulty?

<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes, who have you seen?</b> <input type="checkbox"/> Educational Psychologist <input type="checkbox"/> Doctor <input type="checkbox"/> Counsellor <input type="checkbox"/> Paediatrician <input type="checkbox"/> Therapist <input type="checkbox"/> Speech & Language <input type="checkbox"/> Other (please specify) .....  What was the condition identified/diagnosed? .....
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We are required by the Department for Education to provide them with certain information. Please would you complete the following:

<b>What is your family's Ethnic Group? Please tick one of the following:</b>					
ABAN	Bangladeshi		MWBA	White/Black African	
AIND	Indian		MWBC	White & Caribbean	
AOTH	Any other Asian background		OOTH	Any other Ethnic Group	

APKN	Pakistani		WBRI	White British	
BAFR	Black African		WIRI	Irish	
BCRB	Black Caribbean		WIRT	Traveller – Irish Heritage	
BOTH	Any other Black background		WOTH	Any other White background	
CHNE	Chinese		WROM	Gypsy/Roma	
MOTH	Any other Mixed background		<b>Please select an option above or tick Refused</b>		
MWAS	White/Asian		REFU	Refused	
<b>Child's First Language</b> (main language spoken)					
<b>Home Language(s)</b> (other languages spoken in the home)					

**Are you currently claiming any of the following benefits?**

- Income Support
- Income-based Job Seekers Allowance
- Child Tax Credit (Not Working Tax Credit)

If so, please complete the Bexley Free School Meal application form in this pack and return with your forms.

**Service child in education (Armed Forces)?**

Yes     No

**Mode of Transport: How will your child usually travel to school? Please tick one box only.**

Walk	
Car/Van (The only child travelling, or with other members of the same family)	
Car Share (With a child/children from another family)	
Bus	
Cycle	
Train	
Taxi	
Other (please specify)	

## Parental Consents

Please read carefully the guidance notes in the School Information Booklet before completing these consents. Please complete all sections.

You can change your permissions at any time by writing to the school: [contact@htl.bexley.sch.uk](mailto:contact@htl.bexley.sch.uk)

### **Collection Password**

Any person wishing to collect your child from school will be required to give the password you have provided.

Password: .....

If your child will regularly/occasionally be collected by a person not named as Parent 1 or Parent 2, please provide their details below:

Full Name	Relationship to Child	Contact No: