MOATE COMMUNITY SCHOOL

Church Street, Moate, Co. Westmeath
Telephone: 090 6481350
Email: info@moatecs.com

APPLICATION FORM 2020/2021

STUDENT DETAILS

FIRST NAME:	MIDDLE NAME:	SURNAME:
DATE OF BIRTH:	COUNTRY OF BIRTH:	NATIONALITY:
PROPOSED YEAR OF ENTRY: 20_____ 1st [ ] 2nd [ ] 3rd [ ] TY [ ] 5th [ ] 6th [ ]		MALE [ ] FEMALE [ ]
ENROLLMENT TO THE UISNEACH CENTRE (ASD CLASS) YES [ ] NO [ ] IF YES, PLEASE COMPLETE THE ADDITIONAL UISNEACH CENTRE FORM WHICH IS ATTACHED.		
STUDENT'S PPS NUMBER: (DO NOT LEAVE BLANK)	MEDICAL CARD NUMBER: YES [ ] NO [ ] IF YES, STATE CARD NUMBER	
USING SCHOOL TRANSPORT: YES [ ] NO [ ]	GOING HOME FOR LUNCH: YES [ ] NO [ ]	
PRIMARY SCHOOL ATTENDED:		
SECONDARY SCHOOL ATTENDED: (IF TRANSFERRING)		
STATE EXAMINATIONS TAKEN (IF ANY): PLEASE ATTACH COPY OF RESULTS YEAR:		
HOME ADDRESS:		

FATHER'S DETAILS		MOTHER'S DETAILS	
NAME:		NAME:	
		MOTHER'S MAIDEN NAME:	
OCCUPATION:		OCCUPATION:	
HOME PHONE:		HOME PHONE:	
WORK PHONE:		WORK PHONE:	
MOBILE PHONE:		MOBILE PHONE:	
EMAIL ADDRESS:		EMAIL ADDRESS:	

IF EITHER PARENT RESIDES AT AN ADDRESS OTHER THAN ABOVE, PLEASE SPECIFY:

MOBILE NUMBER FOR SMS (TEXT) MESSAGES:
ONE NUMBER ONLY

TO WHOM SHOULD ALL SCHOOL CORRESPONDENCE BE SENT?

ADDITIONAL EMERGENCY NAME AND CONTACT NUMBER	
NAME:	
PHONE NUMBER:	
RELATIONSHIP TO CHILD:	

IF THERE ARE ANY ORDERS OR OTHER ARRANGEMENTS IN PLACE GOVERNING ACCESS TO, OR CUSTODY OF THE CHILD, PLEASE PROVIDE DETAILS:

DOES THE STUDENT HAVE ANY BROTHERS OR SISTERS IN THIS SCHOOL? YES [ ] NO [ ]
IF YES PLEASE INDICATE NAMES AND THE YEAR THEY ARE CURRENTLY IN:

NAMES OF SIBLING(S) WHO PREVIOUSLY ATTENDED THIS SCHOOL:

EDUCATIONAL DETAILS:

REQUIRED FOR THE ASSESSMENT OF INDIVIDUAL EDUCATIONAL NEEDS

TO ENSURE THE CONTINUATION OF ADDITIONAL RESOURCE TEACHING HOURS AND/OR ADDITIONAL SNA SUPPORT, IT IS ESSENTIAL TO COMPLETE THIS SECTION AND TO ATTACH ALL RELEVANT REPORTS. **THIS INFORMATION SHOULD BE AVAILABLE FROM YOUR CHILD'S PRIMARY SCHOOL**	
HAS THE STUDENT A PSYCHOLOGICAL ASSESSMENT? **IF YES, PLEASE ATTACH REPORT**	**YES [ ] NO [ ]**
DOES THE STUDENT RECEIVE ANY OTHER SUPPORT? **SPEECH & LANGUAGE** **OCCUPATIONAL THERAPY** **PHYSIOTHERAPY** **CAMHS** **PLEASE ATTACH ALL PROFESSIONAL REPORTS**	 **YES [ ] NO [ ]** **YES [ ] NO [ ]** **YES [ ] NO [ ]** **YES [ ] NO [ ]**
HAS THE STUDENT ANY HEARING DIFFICULTIES? **IF YES, PLEASE ATTACH REPORT**	**YES [ ] NO [ ]**
HAS THE STUDENT A VISUAL IMPAIRMENT? **IF YES, PLEASE ATTACH REPORT**	**YES [ ] NO [ ]**
HAS THE STUDENT BEEN GRANTED RESOURCE TEACHING HOURS BY THE NCSE?	**YES [ ] NO [ ]**
HAS THE STUDENT BEEN GRANTED SPECIAL NEEDS ASSISTANT HOURS BY THE NCSE?	**YES [ ] NO [ ]**
HAS THE STUDENT AN IRISH EXEMPTION? **IF YES, PLEASE ATTACH A COPY OF THE EXEMPTION CERTIFICATE**	**YES [ ] NO [ ]**

Moate Community School shall endeavor at all times to comply with the Data Protection Acts 1988, the Data Protection (Amendment) Act 2003 & General Data Protection Regulation (GDPR), which came into force on 25th May 2018

Procedures outlined in the Schools Data Protection Policy which can be viewed on moatecs.com

We Grant permission to Moate Community School:

To photograph our son/daughter, either alone or together with others and to use the image in school publications, on the school website and/or for promotional purposes in local newspapers. Permission is granted subject to an undertaking that the privacy or integrity of our son/daughter's image will be respected at all times.

SIGNED: _____ **PARENT/GUARDIAN**	**DATE: _____**
SCHOOL USE ONLY: **ENROLLED BY: _____**	

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MEDICAL DETAILS

STUDENT NAME:	DATE OF BIRTH:
MOTHER'S CONTACT NUMBER:	FATHER'S CONTACT NUMBER:
DOCTOR'S NAME:	DOCTOR'S TELEPHONE NUMBER:
PLEASE STATE GENERAL HEALTH:	

HAS YOUR CHILD NOW OR PREVIOUSLY HAD?	
HEART PROBLEMS	YES [ ] NO [ ]
RECENT SURGERY	YES [ ] NO [ ]
BREATHING OR LUNG PROBLEMS	YES [ ] NO [ ]
DIABETES	YES [ ] NO [ ]
EPILEPSY	YES [ ] NO [ ]
ASTHMA	YES [ ] NO [ ]
DIFFICULTY WITH PHYSICAL ACTIVITY	YES [ ] NO [ ]
ANY CURRENT INJURIES	YES [ ] NO [ ]
HEARING DIFFICULTIES	YES [ ] NO [ ]
PROBLEMS WITH HIS/HER EYESIGHT	YES [ ] NO [ ]

HAS YOUR CHILD ANY OTHER DISABILITY? YES [ ] NO [ ]	IF YES, PLEASE SPECIFY
HAS YOUR CHILD ANY ILLNESS OR ALLERGIES OF ANY KIND THAT THE SCHOOL MAY NEED TO BE AWARE OF? YES [ ] NO [ ]	IF YES, PLEASE GIVE DETAILS
IS YOUR CHILD CURRENTLY ON ANY MEDICATION? YES [ ] NO [ ]	IF YES PLEASE GIVE DETAILS
IS THERE ANY SPECIAL MEDICAL INFORMATION RELATING TO YOUR CHILD THAT THE SCHOOL SHOULD BE AWARE OF? YES [ ] NO [ ]	IF YES PLEASE GIVE DETAILS
IN THE EVENT OF ACCIDENT OR EMERGENCY, HAS THE SCHOOL YOUR PERMISSION TO SEEK MEDICAL ASSISTANCE FOR YOUR CHILD?	YES [ ] NO [ ]
SIGNED: _____ PARENT/GUARDIAN	DATE:_____