Southwark Transition and Assessment Record (STAR)	**Entry Profile**

1. Name of child:

Male / Female: (please delete as necessary)

2. Name child will be known as at school:

3. DOB:

Date of admission:

4. Address:

5. Phone No:

Home

6. Travel Arrangements to School

Please give details of how your child will travel to school e.g. walking, bus, car

	1st Parent/carer/guardian	2nd Parent/carer/Guardian
1) Name		
2) National Insurance/ No and date of birth.		
3) Mobile No. – this is the number we will use to contact you by text messaging service unless you indicate otherwise		
4) Email address		
5) Place of Work/college		
6) Name known by at work/college		

7. Name(s) of Parent(s)/ Carer(s)/Guardian(s)		

Work/college Telephone no.

8. Names of all children in the family in age order:

	Name	D.O.B		Name	D.O.B
1.			4.		
2.			5.		
3.			6.		

9. Position in family: 1 2 3 4 5 6 7 8

10. Family Structure *(please circle)* One Adult Two Adults

11. Race Ethnicity:

Child:	
Family:	

1**2.**

First Language understood by child:	
First Language spoken by child:	
Language(s) understood by family:	
Language(s) spoken by family:	

13. Religion:

14. Person(s) authorised to take/collect the child (emergency contacts other than those on page 1)

(1) Name:		(2) Name:	
Address:		Address:	

Telephone:		Telephone:	

15. Please provide details of your child's after-school care – extended services

Name:	
Address:	
Telephone:	
Days attended *Please circle as appropriate*	Mon Tues Weds Thurs Fri Everyday

16. Persons **NOT** authorised to collect/have access to your child:

(1) Name:		(2) Name:	
Context: e.g. injunction number			

17. Previous care history and/or access to any programmes or facilities e.g. book start, toy library, one o'clock club:

Name (and address if known) of provider:

18. General Practitioner (Doctor):

Name:	
Clinic:	
Address:	

Telephone:	

Health Visitor:

Name:	
Clinic:	
Address:	
Telephone:	

Immunisations (Please tick as appropriate):

	Date		Date
B.C.G (at birth)		Diphtheria	
Tetanus		Whooping cough	
Hib		Oral Polio Vaccine	
Men C		Measles, Mumps & Rubella	
Pre-School Booster			
Additional inoculations (please specify)			

19. Development checks (last check with HV/GP):

Age:	Date:

20. Dental treatment:

21. Any childhood illnesses?

22. Any distinguishing marks e.g. birthmarks, scars, Mongolian Blue Spot etc?

23. Any important health considerations? Please give details and any special requirements. (Include possible use of asthma inhaler/epipen)

Please specify

Any on-going medication?

Please specify

Any allergies e.g. penicillin, plasters, anaesthetic, food allergies, wasp stings/insect bites?

Please specify

24. Does the child require other aids/adaptations, cups/cutlery? Yes ( ) No ( )

Please list

25. Does the child have Additional Educational Needs? Yes ( ) No ( )

Please specify

26. Does the child have any professional involvement e.g. portage, SALT (Speech & Language Therapy), EIT team (Early Intervention), SW(Social Worker)? –

Please specify

27. History: Birth history / prematurity / time spent in hospital / separation / bereavement / important events

28. Dietary requirements:

29. Toileting requirements:

30. Cultural/religious dress requirements:

Referring to the schools dress code please list items if applicable

31. Fears/Phobias:

32. Tell us about your child's development and what s/he and can do/what they enjoy playing with:

Form completed by:

Provider signature:		Date:	

Parent/carer signature:		Date:	