Greaghrahan NS, Staghall, Belturbet, Co. Cavan. H14CH74
Email: office@greaghrahanschool.ie Tel: 049 9526502
Website: www.greaghrahanschool.ie

APPLICATION FOR ADMISSION OF NEW PUPILS YEAR 2024/2025

Pupil's Name: _____ **Pupil's Surname**: _____

Address:_____**Eircode:**_____

Pupil's Nationality: _____ **Place of Birth:**_____ **Date of Birth:**_____

If not born in Ireland, year in which child arrived in Ireland: _____

Child's PPS No. _____

Number of Children in Family_____ **Position in Family**_____

Father's Name:- _____ **Occupation:**_____

Mother's Name:-_____ **Occupation:**_____

Telephone No: **(Home)**_____ **(Mother)** _____ **(Father)**_____

Details for School text: (preferred mobile no. and e-mail address) Mobile No:_____

E-mail address:_____ **First language**: _____

Religion: _____

Name and address of pre-school / previous school attended _____

_____

Has your child been referred for any of the following: (Please submit any reports with application).

Speech Therapy Yes [] No [] **Psychiatric / Psychological Assessment Yes [] No []**

Hearing Yes [] No [] **Assessment of Needs Yes [] No []**

Occupational Therapy Yes [] No [] **Vision Yes [] No []**

(Should medical concerns arise/change, parents are responsible for informing the school)

School Emergencies/Sickness/Unexpected Closures, etc.
The following information will be used by the school in the event of:
- Your child feeling sick
- An emergency occurring while the school is in operation, making it necessary to close the school. In such an emergency, it is imperative to ensure the safe return home of pupils

Person the school will contact If there is no one at home or the school is unable to contact you, please provide the name and telephone number of two other people you nominate for us to contact. We will ask this person to come and collect your child/children.

1 _____ 2 _____

Tel/mobile: _____ **Tel/mobile:** _____

Family Doctor: _____ **Doctor's Telephone No.** _____

P.T.O.→

Does your child have any specific medical condition (e.g. asthma, eyesight, hearing etc.) or emotional problems which may affect your child at school?

_____

_____

It is the responsibility of parent(s)/guardian(s) to notify the school of any food allergies. **Does your child have an allergic reaction to medication or food?**

_____

_____

_____

Please give names and phone numbers of the people who have permission to collect your child from school. If there is any change in this routine **please inform the school in writing. Person who will usually collect child**

Name:_____ Phone _____
Name:_____ Phone _____
Name:_____ Phone _____
Name:_____ Phone _____

Any other information which you may consider helpful (e.g. phobias, health, family, etc.)

_____

_____

_____

I declare the above information to be correct and understand that it will be treated as confidential.

Note: Pupils may not attend school until after their 4th birthday. **Please ensure that you have included a Birth Certificate with this form**. This will be photocopied and returned to you.

Signed: _____ **Parent/Guardian. Date:** _____

FOR OFFICE USE ONLY

Date Received:	4 years on:	POD:
Registration No:		