

PRIMARY SCHOOL FREE BREAKFAST

Please complete and return to the school by

Child's name:		Class:		
Attendance				
Please indicate which days your child will be attending the breakfast session				
Mon	Tues	Wed	Thurs	Fri
Special Dietary requirements				
Does your child have any food allergies/intolerance? Yes <input type="checkbox"/> No <input type="checkbox"/>				
If yes, please provide details				
Other Information				
Please provide details of any other information you feel relevant to your child's attendance at the breakfast session				
Contact details in case of an emergency				
Name:		Phone number:		
Relationship to child:				
Name:		Phone number:		
Relationship to child:				
I confirm that I would like my child to attend the breakfast sessions when they start.				
Signature of Parent/Guardian:				
Date:				