PRIMARY SCHOOL FREE BREAKFAST

School Name: _____

Please complete and return to the school by: _____

Child(ren)'s name	Date of Birth	Class

Attendance

Please indicate which days your child will be attending the breakfast session

Mon	Tue	Wed	Thur	Fri

Special Dietary Requirements

Does your child have any food allergies/intolerance? If yes, please provide details below:	Yes	No
Child Name	Allergy / intolerance	
Child Name	Allergy / intolerance	
Child Name	Allergy / intolerance	

Other information

Please provide details of any other information you feel relevant to your child's attendance at breakfast sessions

Contact details in case of an emergency

It is important to fully complete the information below in case of an emergency

Home address of child(ren)	Name:	Phone Number:
	Relationship to child:	
	Name:	Phone Number:
	Relationship to child:	
	Name:	Phone Number:
	Relationship to child:	
	I confirm that I would like my child(ren) to attend the breakfast sessions	
	Signature of Parent / Guardian:	Date: