SCOIL AN CHROÍ RÓ NAOFA SÓIS
SACRED HEART JUNIOR SCHOOL
CILL AN ARDÁIN / KILLINARDEN
TAMHLACHT / TALLAGHT
BÁILE ÁTHA CLIATH 24 / DUBLIN 24
FÓN: 01–4524064 TEL: 01–4524064
Roll: 19652B

Early Start Application Form 2026/27

Child Information

Name of Child: _____ PPS No: _____

Address: _____ Proof: ☐

Date of Birth: _____ Birth Certificate: ☐ Nationality: _____

Home Phone: _____ Mobile Phone: _____

Religion: _____

Previous Pre-School Attended: _____

N.B.: Please contact us if the above address or phone numbers change while your child is in this school.

Developmental History

Did your child crawl? _____If yes, at what age? _____

At what age did your child walk? _____

At what age did your child speak his/her first word? (please tick)

6–9 months ☐ 9–12 months ☐ 12–15 months ☐ Other ☐ (please specify)
_____

Is your child receiving speech therapy? Yes ☐ No ☐

Is your child on a waiting list for speech therapy? Yes ☐ No ☐

How was toilet training? (please circle) Normal / Difficult / Slow

Are there any other issues or reports that the school may need to know about?
_____

Concerns

If you have concerns about your child with regard to any of the following, please circle:

Speech Eyesight Hearing Development

Are you concerned about any aspect of your child's behaviour? _____

Has there been any major trauma in your child's life? _____

Medical

Please tell us about any medical factors which might affect your child in Early Start, e.g. asthma, epilepsy, food allergies, medication.

_____

Family Details

Mother / Legal Guardian Name: _____ Phone: _____

Address: _____

Work No: _____ E-Mail: _____

Father / Legal Guardian Name: _____ Phone: _____

Address: _____

Work No: _____ E-Mail: _____

Parents / Legal Guardians Nationality: _____

Parents / Legal Guardians 1st Language: _____

No. of children in family: _____ Place of child in family: _____

Names of brothers/sisters already in this school:

Name: _____ Class: _____ Name: _____ Class: _____

My child will enter Junior Infants in this school: Yes ☐ No ☐

Emergency Contact

Please note: In the event of an accident/emergency, the school will phone an ambulance first, then parents/guardians.

If we cannot reach you, please provide two alternate contact persons:

No.1 - Emergency Contact Name: _____ Phone: _____
Relationship to child: _____

No.2 - Emergency Contact Name: _____ Phone: _____
Relationship to child: _____

N.B.: Please inform us if the above information changes while your child is in this school.

Session Preferences

Morning Session: 9.00 a.m. – 11.30 a.m.
Afternoon Session: 12.00 p.m. – 2.30 p.m.
If your child is offered a place, please tick your preference below:
Morning Session ☐ Afternoon Session ☐ Either ☐

Note: We may not be able to accommodate your preference but will do our best, based on the date of application.

Has your child had, or is in the process of having, an assessment of need? Yes ☐ No ☐

If yes, please attach details.

We have been strongly advised by the Health Service Executive that children have all their Primary Immunisations prior to school entry.

Please tick if your child has been immunised against the following:

Diphtheria ☐ Polio ☐ Tetanus ☐ Hib (Type B Meningitis) ☐ Whooping Cough ☐
Meningitis 'C' ☐

Parent / Guardian Contract

I/we, as parents/legal guardians of _____, confirm that the information on this form is true and agree to support the policies of Early Start and work in co-operation with the staff.

Signed: _____ Date: _____

Parent(s) / Legal Guardian(s)

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Meningitis 'C' ☐

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