



**After School Hours Service**

Tel: 22586810  
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Indirizz: Foundation for  
Educational Services,  
P.O. Box 1,  
Rabat RBT 1000, Malta

**REGISTRATION FORM**

How did you hear about Klabb 3-16?  Friend  School  Magazine / Advert  Website  Other

What is the reason for using Klabb 3-16?  Work  Studies  Respite  Recreation  Other

<b>Ċentru</b>	<input type="checkbox"/> Victoria	<input type="checkbox"/> Mġarr	<input type="checkbox"/> Rabat	<input type="checkbox"/> Żabbar
(aghżel wiehed minn dawn)	<input type="checkbox"/> St Paul's Bay	<input type="checkbox"/> Mellieha	<input type="checkbox"/> Mosta	<input type="checkbox"/> Naxxar
	<input type="checkbox"/> B'Kara	<input type="checkbox"/> Sta Venera	<input type="checkbox"/> Fgura	<input type="checkbox"/> M'Scala
	<input type="checkbox"/> Luqa	<input type="checkbox"/> Żebbuġ	<input type="checkbox"/> Siġġiewi	<input type="checkbox"/> Qormi SĠ
	<input type="checkbox"/> San Ġwann	<input type="checkbox"/> Pembroke	<input type="checkbox"/> Sliema	<input type="checkbox"/> St ..
	<input type="checkbox"/> Attard	<input type="checkbox"/> Hamrun	<input type="checkbox"/> Żejtun	<input type="checkbox"/> Paola
	<input type="checkbox"/> Żurrieq	<input type="checkbox"/> Birżebbuġa		

*The following information is confidential*

**CHILD 1 INFORMATION**

Surname \_\_\_\_\_ Name \_\_\_\_\_ I.D. No: \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Age \_\_\_\_\_  Male  Female  
 School \_\_\_\_\_  
 Place of birth \_\_\_\_\_  
 Language/s \_\_\_\_\_  
 Child lives with  Parent/Guardian 1  Parent/Guardian 2  Both  
 Check all that apply to your child, or check "None" for those that don't apply:

<input type="checkbox"/> <b>Allergies</b>	Specify: _____	<input type="checkbox"/> None
<input type="checkbox"/> <b>Medical Condition</b>	Specify: _____	<input type="checkbox"/> None
<input type="checkbox"/> <b>Disability</b>	Specify: _____	<input type="checkbox"/> None
<input type="checkbox"/> <b>Special circumstances</b>	Specify: _____	<input type="checkbox"/> None

**PARENT 1 DETAILS**

Surname \_\_\_\_\_ Name \_\_\_\_\_ I.D. No: \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_ Postcode \_\_\_\_\_  
 Tel (home) \_\_\_\_\_ Tel (work) \_\_\_\_\_  
 Mobile \_\_\_\_\_ Email \_\_\_\_\_  
 Language/s \_\_\_\_\_  
 Place of work: \_\_\_\_\_ Hours of work: \_\_\_\_\_

**PARENT 2 DETAILS**

Surname \_\_\_\_\_ Name \_\_\_\_\_ I.D. No: \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_ Postcode \_\_\_\_\_  
 Tel (home) \_\_\_\_\_ Tel (work) \_\_\_\_\_  
 Mobile \_\_\_\_\_ Email \_\_\_\_\_  
 Language/s \_\_\_\_\_  
 Place of work: \_\_\_\_\_ Hours of work: \_\_\_\_\_

**CUSTODY ACCESS** *Who has custody access to child/ren?*

Names of those who have custody: \_\_\_\_\_  
 Is there a court order in place:  Yes  No - If YES, please speak to Centre Co-ordinator.

**TAX REBATE:** Passing my details to the Inland Revenue Department for the purpose of benefitting from any tax concessions offered, should this information be requested. Please fill accordingly.

Yes  No If yes, name of parent making the claim: \_\_\_\_\_

**EMERGENCY CONTACT 1 DETAILS**

Surname _____	Name _____
Address _____	
Tel (home) _____	Tel (work) _____
Mobile _____	Relationship _____

**EMERGENCY CONTACT 2 DETAILS**

Surname _____	Name _____
Address _____	
Tel (home) _____	Tel (work) _____
Mobile _____	Relationship _____

**DISCLAIMER**

I wish to enrol my child/children at Klabb 3-16 After-school hours Care Service on the the days specified above. I understand that Klabb 3-16 staff will take reasonable care of my child/children and I will not hold them responsible for any damage and/or loss of property and/or accident. I realise that I am responsible for informing Klabb 3-16 staff of any medical conditions that may affect my child's participation in the programme.

**PARENT/GUARDIAN STATEMENT**

The information given in this statement is true and correct.

**SPECIAL CIRCUMSTANCES**

Parents/guardians are required to inform Klabb 3-16 in writing, prior to a child's acceptance at Klabb 3-16, of any special circumstances which may affect the child's ability to participate fully. The abilities referred to are related with the guidelines of acceptable behaviour, including but not limited to any serious behavioural problems or special circumstances regarding medical, physical or pshychological conditions. Upon being informed of such circumstances, the Centre Co-ordinator may require a meeting with the parent(s)/guardian to discuss issues that may develop by these circumstances.

By submitting this application you are giving your permission for the oportune first aid treatment to your child to be administered by qualified staff members. While understanding that you would be contacted by a programme personnel as soon as reasonably possible regarding any emergency involving your child, you are giving your permission for your child to be transported to hospital or any other emergency medical facility in the occurrence of a serious illness or injury, where ambulance or rescue squad members would be authorised to administer all necessary treatments. You are also giving your authorization for warranted health practitioners to examine and provide the necessary emergency medical treatment to your child in your absence.

I understand and acknowledge that: (i) it is the responsibility of the parent(s)/guardian to make full disclosure to Klabb 3-16 of any special circumstances which may affect the ability of my child/ren to participate in the programme; (ii) it is the responsibility of the parent(s)/guardian(s) to inform Klabb 3-16 of any particular needs required for the child/ren to participate in the programme; and (iii) I trust Klabb 3-16 to evaluate and assess whether the request is required and if it should be put in place.

<b>Signature Parent1/Guardian1</b>		<b>Date</b>
<b>Signature Parent2/Guardian2</b>		<b>Date</b>

Documents that need to be presented with this form	For Office Use Only
Copy of ID card of parent / guardian <input type="checkbox"/>	Registration Date: _____
Copy of ID Card of person authorised to collect the child/ren from Klabb 3-16 Centre <input type="checkbox"/>	Payment with Registration Yes <input type="checkbox"/> No <input type="checkbox"/> Amount: € _____

Statementing report (where applicable) <input type="checkbox"/> IEP report (where applicable) <input type="checkbox"/> Legal Documents regarding Guardianship and/or Custody (where applicable) <input type="checkbox"/> Original Birth Certificates <input type="checkbox"/> <i>In the case where there are Custody and Care arrangements, the original birth certificate needs to be presented to confirm the submitted details. (The certificate is returned after processing).</i>	Date when the Coordinator met the parent/guardian _____ Date of Service Commencement _____ Date of Termination of Service and reason _____
<b>Coordinator Signature</b>	

***Application forms are to be taken to the centre where the service is required and are to be handed in by hand***



I would like to acknowledge receipt of your application for Klabb 3-16 service at \_\_\_\_\_ Klabb 3-16 Centre in respect of \_\_\_\_\_ (name of child). Kindly always quote the Registration Number \_\_\_\_\_ when referring to your application.

Date: \_\_\_\_\_

\_\_\_\_\_  
Centre Coordinator