



Child Registration Form (CRF)

Child details:

Date: _____

Name: _____

DOB: _____

School/Pre-School _____

Medical issues/Allergies _____

First Language _____

Family details:

Parent/Carer name (1) _____

Relationship to child _____

Legal responsibility for child _____

Address: _____

Telephone: _____ Email: _____

First Language _____

Parent/Carer name (2) _____

Relationship to child _____

Legal responsibility for child _____

Address: _____

Telephone: _____ Email: _____

First Language _____

Services you require:

Speech & Language Therapy Music Therapy Art Therapy Play Therapy

Physiotherapy Nutritional Therapy Psychology Services Not Sure

We can contact you to arrange appointments: by email by phone by post

We can contact you to send all relevant documents: by email by post



Please return the completed form by post to:

Sensory Space
Unit 5
Dublin Road
Drogheda
Co. Louth A92 XE86

Alternatively, scan and email to: **info@sensoryspace.ie**

If you have any queries, please phone: **041 980 3307**