



GSM-Enrolment Enquiry

Parent Guardian Name

Phone

Email

Date

Child's Name	Date of Birth	Preferred Start Date	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Times/Hours of Care
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Does the child/children have any medical conditions or additional needs

How did the person hear about our Service?

Details (who were they referred by, which search engine/social media site etc)

Word of mouth

Internet search

Social Media

Associated Service (Church or School)

Signage

Other

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**Follow Up** (Date[s] contacted, contact method and notes)

Name of person recording the enquiry

Date

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Did the family enrol? *If 'No' provide reason*    Yes     No