

Membership Form



Parent information:

Name (please print): _____

Address: _____

_____ Post-code: _____

Email Address (please print): _____

Contact Telephone Number: _____

How would you prefer us to contact you?	
By email	
By post	
By text	

For **free** text information please include your mobile phone number: _____

- Gender:** Male Female I prefer not to tell you
- What is your Age?** Under 16 16 – 25 26 – 35 36 -45
- 46 – 55 56 – 65 66+ I prefer not to tell you
- What is your Religion or Belief?** Christian Buddhist Hindu Sikh
- Jewish Muslim Atheist Agnostic
- I prefer not to tell you Other – Please tell us _____
- What is your Sexual Orientation?** Heterosexual (Man and Woman) Lesbian Gay
- Bisexual I prefer not to tell you Other – Please tell us _____

What is your ethnic group?

White	Mixed	Asian or Asian British	Black or Black British	Chinese or other ethnic group
<input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other White Background Please tell us:	<input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian <input type="checkbox"/> Any other Mixed background Please tell us:	<input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Tamil <input type="checkbox"/> Korean <input type="checkbox"/> Any other Asian background Please tell us:	<input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other Black background Please tell us:	<input type="checkbox"/> Chinese <input type="checkbox"/> Any other background Please tell us:
<input type="checkbox"/> I prefer not to tell you my ethnic group				

Disability and Health

- Do you have a long-term physical or mental health condition or disability?
- Yes No I prefer not to tell you
- If yes, what is the nature of your disability, mental health or other health issue?
- Physical/Mobility Sensory Mental Health
- Learning Disability Health Diagnosis I prefer not to tell you
- Other – Please tell us _____

Please tell us if your family includes someone (other than you) with a Disability Yes / No

If it is a child are they on the Disabled Children’s Register? Yes / No

Children’s information:

Child’s name	Date of Birth	Sex m/f	Which school does your child/children go to?

Data Protection Statement

The personal details you have provided will be used by the Parents Forum for the following purposes:

- To inform you of Parents Forum news and events
- To send you consultation questionnaires in between events.
- To provide the Parents Forum with statistical information about the membership of the forum and their families

Your information is held by the Parents Forum working group and will not be shared with a Third Party. **Please sign below to say you have read the above and agree to your family's details being held on the Parents Forum membership list.**

Signed: Date:

MOISTEN, FOLD AND SEAL

Please fold this questionnaire, seal it and put it in the post (no need for a stamp).

If you require this document in another language or an alternative format such as large print or audio-tape, please contact the Council's helpline on
020 8547 5757.

www.kingston.gov.uk

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