

DATE RECEIVED: _____ (OFFICE USE ONLY)



HOMESTAY REGISTRATION FORM


LAST NAME:	DATE OF BIRTH:		INSERT / ATTACH PHOTO HERE
FIRST NAME:	AGE:	MALE / FEMALE:	
ADDRESS:			
TELEPHONE NUMBER:			
EMAIL ADDRESS:			


EMERGENCY CONTACT NAME AND CONTACT DETAILS <i>THIS MUST BE A CLOSE RELATIVE E.G. FATHER, MOTHER, BROTHER OR SISTER</i>	LAST NAME:
	FIRST NAME:
	THEIR RELATION TO YOU:
	ADDRESS:
	MOBILE NUMBER:
	EMAIL ADDRESS:






DATE OF TRAVEL TO THE UK:	DATE OF ARRIVAL IN CARDIFF:
LENGTH OF HOMESTAY REQUIRED (WEEKS):	DATE OF DEPARTURE FROM CARDIFF:



DO YOU EAT?	YES ☺	NO ☹
Chicken		
Pork / Ham / Bacon		
Lamb		
Beef		
Fish		
Eggs		
Milk		
Cheese		

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 IS THERE ANYTHING YOU DON'T EAT?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
	<i>If yes, please specify here:</i>	

 DO YOU SMOKE?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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DO YOU HAVE ANY ALLERGIES TO?	YES - ☹️	NO - 😊
 Dust		
 Feathers		
 Dogs		
 Cats		
 Other	<i>If yes, please specify here:</i>	

 DO YOU HAVE AN ILLNESS OR MEDICAL CONDITION? YES <input type="checkbox"/> NO <input type="checkbox"/>	If YES, please write the details of your illness or medical condition here:
HAVE YOU HAD ANY SERIOUS ILLNESS OR MEDICAL CONDITONAL IN THE LAST THREE YEARS? YES <input type="checkbox"/> NO <input type="checkbox"/>	If YES, please write the details of your illness or medical condition here:
 ARE YOU CURRENTLY TAKING ANY MEDICATION? YES <input type="checkbox"/> NO <input type="checkbox"/>	If YES, please write the details of your medication here:

BY SIGNING THIS FORM, I CONFIRM THAT THE ABOVE DETAILS ARE TRUE.

SIGNED (NAME) _____ DATE _____