

REGISTRATION FORM

Child's Details:

Child's Surname: _____
 First Name: _____ Name by which Child is known: _____
 Gender: Male/Female: _____ Nationality: _____
 Religion: _____ Date of Birth: _____
 Residential Address: _____

 Telephone Numbers: _____ **Emergency Telephone No.:** _____
 Last School & Class Attended if Any: _____

Please attach 2
current passport
sized photograph
of your child

Father/Guardian Full Name: _____ Profession: _____
 Business Name & Address: _____
 _____ Tel No.: _____
 Mother's Full Name & Address: _____ Profession: _____
 _____ Tel No.: _____
 Father's Nationality: _____ Mother's Nationality: _____
 Email addresses: Father: _____ Mother: _____

Additional Information:

Does your child have any known educational or other special needs? _____

 Do you have any concerns about your child's development? Yes () No () If yes
 Please comment: _____

Medical Information

Does your child have any known allergies or pre existing medical conditions? If so please explain.
 Please comment: _____

Immunization Records

Please indicate the dates the Immunization were taken _____

For Official Use Only

Date form collected: _____ Receipt Number: _____ Amount paid: _____

Date form return: _____ Received by: _____

Supporting documents checklist: (Please tick)

Copy of birth certificate: Transfer certificate:

Passports photographs: Last report:

Immunization card:

Authorized by Director: _____ Date: _____