



Registration Form

Please complete all sections in full.

Date:

Class/Yr:

Age:

1. Family Information

Child's name	
Place and date of Birth	

2. Parents information

Mother's name	
Mother's address and contact information	Residential address:
	Personal e-mail:
	Cell phone:
Mother's work place information and contacts	Name of employer
	Workplace Telephone
	Workplace e-mail

Father's name	
Father's address and contact information	Residential address:
	Personal Email:
	Cell phone:
Father's work place information and contacts	Name of employer
	Workplace Telephone
	Workplace email

3. Siblings

Child's name	Age	School

4. Additional contacts during emergency

Name	Mobile Number	Relationship with the child

5. Student Medication information

<p>Does the student have an existing medical condition? If yes, please provide details and attach any relevant medical reports and instructions</p>
<p>Does the student suffer from any allergies (food, medicine, etc.)? If yes, please provide details and attach any relevant medical reports and instructions</p>
<p>Is the child required to take regular medication during the day time? If yes, please provide details and instructions on how to administer the medicine</p>
<p>Child's Blood group</p>
<p>Preferred Family Doctor in case of medical emergency</p> <p>Doctor's name:</p> <p>Doctor's cell phone:</p> <p>Name of hospital / clinic:</p>
<p>Medical Insurance: Please attach a photocopy of the child's medical insurance card</p>

6. Declaration

We confirm that the information provided above is correct

Mother's signature:

Father's signature: