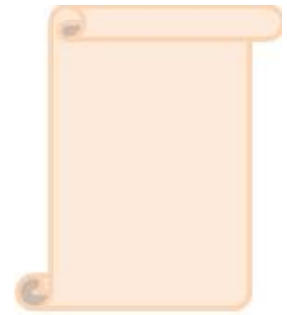


Reg. No. :

Date:



Childs Name: (last name) \_\_\_\_\_ (Middle Name) \_\_\_\_\_ (First Name) \_\_\_\_\_

Birth Date: (DD) \_\_\_\_\_ (MM) \_\_\_\_\_ (YY) \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M / F

Birthplace: \_\_\_\_\_ Nationality: \_\_\_\_\_

Current Residence: \_\_\_\_\_

Native Language: \_\_\_\_\_ Other Languages: \_\_\_\_\_

### Family Information

#### **Mother**

Name: \_\_\_\_\_

Nationality: \_\_\_\_\_

Profession: \_\_\_\_\_

Qualification: \_\_\_\_\_

Designation: \_\_\_\_\_

Home Phone No.: \_\_\_\_\_

Mobile Phone No.: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

#### **Father**

Name: \_\_\_\_\_

Nationality: \_\_\_\_\_

Profession: \_\_\_\_\_

Qualification: \_\_\_\_\_

Designation: \_\_\_\_\_

Home Phone No.: \_\_\_\_\_

Mobile Phone No.: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

### Emergency Contacts

Name: \_\_\_\_\_

Contact No.: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

### Medical Information

Allergies: \_\_\_\_\_

Food Restrictions / Special Diets: \_\_\_\_\_

Does your child have any relevant illnesses?  No  Yes; \_\_\_\_\_

Is your child under any medical treatment?  No  Yes; \_\_\_\_\_

Other important information: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ ContacNo.: \_\_\_\_\_

**What do you want your child to be in 20 years from today?** \_\_\_\_\_

\_\_\_\_\_