Greenacre International School

Growing together, Working together, Learning together

Registration Form

By registering you will be asked to provide us with details of yourself and your children. Our staff will help guide you through this process, therefore please ask if you have any questions. Completing this form does not bind you to any legal or financial obligation.

Details of Child **1**:

Name of child : ..... DOB (D/MY): ..... Age : .....

Male ◯ Female ◯

Nationality (if dual then state both) : .....

Visa Status (if foreign national) : .....

Previous school : ..... School year level : .....

Any special note about your child : .....

.....

Details of Child **2** :

Name of child : ..... DOB (D/MY): ..... Age : .....

Male ◯ Female ◯

Nationality (if dual then state both) : .....

Visa Status (if foreign national) : .....

Previous school : ..... School year level : .....

Any special note about your child : .....

.....

Detail of Guardian :

Name of Guardian : ..... Relationship to child : .....

Nationality : .....

E-mail : ..... Phone number : .....

Address : .....

Notes : .....

Confidential health questionnaire

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Child's name: .....

Age: ..... ◯ Male ◯ Female Date of Birth .....

Family doctor ..... Phone: .....

Please answer the following questions as accurately as possible:

1. Does your child have any special health needs or problem that the school should know about ? Yes / No
   Details: .....
2. Does your child take any medication on regular basis? Yes / No
   Details .....
   Do they need to take it during school hours ? Yes / No
3. Is your child going to a hospital, clinic or doctor for ongoing treatment now ?
   Details .....
4. Has your child ever had any serious illness, broken bones or surgery? Yes / No
   Details .....
5. Is your child allergic to anything such as foods, plants , insects or medicine ? Yes / No
6. Has your child had any convulsions (fits , seizures) in the last year ? Yes / No
   Type of seizure … ..... How many ..... Date of last seizure .....
7. Does your child have any special dietary requirements? Yes / No
   Vegetarian ◯ Vegan ◯ Dairy-free Gluten –free ◯ Other ◯ (Please specify)
   Details .....
8. Does your child have a dentist?
   Name ..... Date or last visit .....
9. Has your child ever been diagnosed with: .

1. Measles	Y/N	2. German measles	Y/N	3. Mumps	Y/N
4. Chicken pox	Y/N	5. Pneumonia	Y/N	6.Dengue	Y/N
7. Whooping cough	Y/N	8. Hand, Foot and Mouth	Y/N	9. Malaria	Y/N
10.Asthma	Y/N	11.Diabetes		12. Meningitis	Y/N
13.Tuberculosis	Y/N	14. Any other			

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10. Does your child have problems with any of the following (please circle):

1. Wheezing/shortness of breath	2. Fainting	3. Headaches
4. Vision	5. Hearing	6. Nosebleeds
7. Throat Infections	8. Coughs/Colds	9. Stomach Aches
10.Vomiting	11. Eczema	12. Rashes
13.Swollen joints	14. Sleeping Circulation/Blood	15. Diaorrhea

Please give details

eat regular meals Yes / No

12. What time does your child go to bed?
13. Are your child's vaccinations up to date Yes / No / Not sure

If you answered No or Not sure, would you like the school to source vaccination information for you? Yes / No

14. Put a circle around any of the following that concern you about your child. (Foundation Stage to Year 3 only)

Bedwetting	Wetting during the day	Thumb sucking	Stuttering
Easily upset	Shy	Attention seeking	Separation anxiety
Day dreaming	Nightmares	Temper tantrums	Stubborn/ contrary
Disobedience	Lying	Selfish/unable to share	Sibling jealousy

Fighting with other children Purposely destroying things Eating habits Other

Please give details

In the event of a minor accident or mild illness, do you consent to the following treatment to be administered to your child?

Basic First Aid (including use of iodine ointment and dressings) Yes / No

Fever Medication (paracetamol) Yes / No

In the event of more serious accident or illness, I would like my child to be treated at the following medical facility;

(Name of hospital)

I certify that the information given on this form is true and correct.

Signed Print

Relationship to child Date____/_____/_____

First Contact in emergency

Mother ☐ Father ☐ Other ☐

Details of emergency contact