

Registration Form

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|-------------------------|--|------------------|--|
| Name of Student: | | Gender | |
| Date of Birth: | | Phone No. | |

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|----------------------------|
| Residential Address |
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|---|--|
| Last school attended details (Name of school, highest grade completed) | |
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|---|
| Parents Information: (Name, Phone Number, Email, Relationship to Child) #1 |
| |

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|---|
| Residential Address (same as child) <input type="checkbox"/> |
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|---|
| Parents Information: (Name, Phone Number, Email, Relationship to Child) #2 |
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|---|
| Residential Address (same as child) <input type="checkbox"/> |
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Please list all of your child's allergies (food, environmental, etc.) if applicable.

Name and Phone Number of Primary Care Physician:

Health Card Number:

**Does your child have (a) learning disability(ies) that has/have been diagnosed?
Please list or indicate N/A. If yes, please provide details.**

Emergency Contact Person (Name, Phone Number, Address, Email, Relationship to child)
