

Gentle Scholars Academy (G.S.A.)

Registration Form

Full Name of Child Date of Birth

Current Age of Child Gender

Address.....

Home Phone Mobile Phone..... Work Phone

E-mail..... WhatsApp Phone Number.....

Do you wish to be added to G.S.A. WhatsApp group?

Father's Information

Name..... Contact

Place of Employment.....Position.....

Mother's Information

Name..... Contact

Place of Employment.....Position.....

Guardian Information

Name Contact

Place of Employment.....Position.....

Emergency Contacts

Name..... Relationship..... Phone

Name..... Relationship..... Phone

Name..... Relationship..... Phone

TRUSTED INDIVIDUALS TO PICK UP CHILD (please include a picture of these persons)

Gentle Scholars Academy (G.S.A.)

Name..... Contact..... Vehicle Number.....

Name..... Contact..... Vehicle Number.....

Are there any current court cases or custody arrangements for the child?

If yes, briefly please explain

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Permission for photographs and short videos

Do you give permission for Gentle Scholars Academy to take photographs and short videos of your child during activities, which may be shared on our official website and social media pages to highlight our vibrant school community and celebrate student achievement? (Please note: We ensure children are presented respectfully and securely.)

Yes, I give permission

No, I do not give permission

Any other information

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Relationship to child Name in Block Letters

Parental Signature

For Official Comments Only

Medical Form

Gentle Scholars Academy (G.S.A.)

Full Name of Child..... Date of Birth.....

Address.....

Phone..... Place of Birth.....

Father's Name..... Mothers Name.....

Mother's Maiden Name.....

Medical history

Allergies.....

Childhood Diseases

Chronic Medical Condition

Accident/Serious Illnesses/Injuries.....

Is there any suspicion or has your child been diagnosed with any disability or are they on the spectrum for Speech Delay, ADHD or Autism or any such like? If Yes, kindly state below.

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IMMUNIZATION

YOU ARE REQUIRED TO SUBMIT AN OFFICIAL ORIGINAL AND COPY OF YOUR CHILD'S IMMUNIZATION CARD AT THE TIME OF REGISTRATION.

Name of Physician..... Name of Dentist.....

Place where immunizations were received

Wears Glasses: Yes No Hearing Aid: Yes No

Signature of Parent/Guardian Stamp & Signature of Medical Doctor