

Tel. No.:



Child Code:

Name of Program : ☐ Parent Toddler Program ☐ Play Group ☐ Nursery ☐ Jr. KG. ☐ Sr. KG.

Batch:

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Timing: From

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 To

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Mother's /
Guardian's
Photo

[illegible]

Gender: ☐ Male ☐ Female

[illegible][illegible]

Blood Group:

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Uniform Size: Regular: 18 20 22 24 26

Winter : 18 20 22 24 26

[illegible][illegible]

Area	Landmark
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City

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 State

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 Pin

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[illegible]

Child stays/lives with: ☐ Mother ☐ Father ☐ Both

☐ Others (Please specify):

**Mother's/Guardian's Details:**

Name:	<input type="text"/>
Residential Address: House number	<input type="text"/>
Street	<input type="text"/>
Area	<input type="text"/>
Landmark	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Pin	<input type="text"/>
Contact no.	<input type="text"/>
Qualification	<input type="text"/>
Occupation	<input type="text"/>
Designation	<input type="text"/>
Office Address:	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
Pin :	<input type="text"/>
Contact no.:	<input type="text"/>
Mobile no.:	<input type="text"/>
Email:	<input type="text"/>
Medical History	<input type="text"/>
	<input type="text"/>
	<input type="text"/>

Father's/Guardian's Details:

Name:	<input type="text"/>
Residential Address: House number	<input type="text"/>
Street	<input type="text"/>
Area	<input type="text"/>
Landmark	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Pin	<input type="text"/>
Contact no.	<input type="text"/>
Qualification	<input type="text"/>
Occupation	<input type="text"/>
Designation	<input type="text"/>
Office Address:	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
Pin :	<input type="text"/>
Contact no.:	<input type="text"/>
Mobile no.:	<input type="text"/>
Email:	<input type="text"/>
Medical History	<input type="text"/>
	<input type="text"/>
	<input type="text"/>

Siblings Name (if any)	Gender	Date of Birth	School Attending	Standard	Kidzee Alumni (Y/N)

Additional Members in the family:

Name	Gender	Relationship to Child	Date of Birth



MEDICAL HISTORY

Child's Immunization History

Age	Recommendation	Dose 1 m/d/y	Dose 2 m/d/y	Dose 3 m/d/y	Dose 4 m/d/y	Dose 5 m/d/y	Booster m/d/y
Birth	BCG Oral Polio Hep B						
6 Weeks	Oral polio DPT Hep B						
10 Weeks	Oral polio DPT						
14 Weeks	Oral polio DPT						
6-9 Months	Oral polio Hep B						
9 Months	Measles						
15 Months	MMR						
18 to 24 Months	Oral Polio+ DPT- 1st Booster						
2 Yrs and 5 Yrs	Typhoid Vaccine						
4 to 4 ½ Years	Oral Polio DPT- 2nd Booster						
10 Years	TT (Tetanus)- 3rd booster Hep B Booster						

EMERGENCY CONTACT

In the event, the parents/guardians cannot be reached, the school will call the people listed below: People listed should be individuals who can 1. Give permission to administer health care, 2. pick up the child if the child is ill or 3. give advice about caring for your child.

Name: <input type="text"/>	Name: <input type="text"/>
Address: <input type="text"/>	Address: <input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/> Pin: <input type="text"/>	<input type="text"/> Pin: <input type="text"/>
Home Phone: <input type="text"/>	Home Phone: <input type="text"/>
Mobile No.: <input type="text"/>	Mobile No.: <input type="text"/>
E mail ID: <input type="text"/>	E mail ID: <input type="text"/>
Relationship with the child: <input type="text"/>	Relationship with the child: <input type="text"/>



Family Doctor

Name:

Address:

Pin:

Home Phone:

 Mobile No.:

E mail ID:

Does your child have any allergies

(food, medications, environment, insects, animals etc.)? ☐ Yes ☐ No

If "Yes" please explain including his/her response to offending substances and recommended treatment for effective relief:

Does your child have any physical, emotional or behavioural issues that may interfere with his/her learning?

☐ Yes ☐ No

If "Yes" please explain

At home, does your child take any daily medication? ☐ Yes ☐ No

If "Yes" please explain including name of medication, dosage, route of administration and rationale for administration

Is there any further information you feel we should know that may help us understand your child?

Any other comments, which might be useful to the school authorities in managing your child's healthcare:



Emergency Permission

I give my consent for emergency measures to be taken in case of an emergency situation arising due to an accident/ violent injury/medical or surgical emergency with the understanding that I (the father/the mother/the guardian of the child) shall be notified/informed as soon as possible. The school will accept no responsibility for any unforeseen incident that may occur due to the administration of medicine/treatment in both emergency and non-emergency situations, though necessary precautions are taken.

Field Trip Permission

I do hereby allow my child to attend the field trips planned and arranged by the centre and I shall not hold KIDZEE authorities responsible for any mishap during the said trip.

Date:

Place:

Parent's/Guardian's Signature

I/We, parent(s)/guardian (s) of _____ have read the rules, regulations and guidelines applicable in respect of the KIDZEE as given and have understood the same and have thereafter decided to enrol my son/daughter at the school. I/We hereby agree and undertake to abide by all the policies of the KIDZEE and to strictly adhere to all the rules and guidelines as laid down by them.

Verification

I hereby verify that I have read the information included on this form and that to the best of my knowledge the information provided by me is complete and correct.

Date:

Place:

Parent's/Guardian's Signature

For office use only

Batch details:

Timing:

Invoice / Receipt No.:

Date:

Amount:

Signature with Seal/Stamp