todd Addess :

Tel. No.:

todd®
Preschool. Activity Center

Form No.:

Child Code:

CHILD REGISTRATION FORM

Name of Program : ☐ Activity Center ☐ Play Group ☐ Nursery ☐ Jr. KG. ☐ Sr. KG.

Batch: _____ Timing: From _____ To _____

Child's Photo	Father's / Guardian's Photo	Mother's / Guardian's Photo

Name of the child: _____

(Surname) (First name) (Middle Name)

Gender: ☐ Male ☐ Female

Date of birth: _____ Place of birth: _____

Height (Cm): _____ Weight (Kg): _____

Blood Group: _____

Uniform Size:

Regular: ☐ 18 ☐ 20 ☐ 22 ☐ 24 ☐ 26

Winter : ☐ 18 ☐ 20 ☐ 22 ☐ 24 ☐ 26

Language(s) spoken at home: _____

Address: House number _____ Street name _____

Area _____ Landmark _____

City _____ State _____ Pin _____

Contact No.: Tel. No. _____ _____ Mobile No. _____

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

☐ Others (Please specify): _____

todd
Preschool. Activity Center

Mother's/Guardian's Details:

Name: _____

Residential Address: House number _____

Street _____

Area _____ Landmark _____

City _____ State _____ Pin _____

Contact no. : _____

Qualification : _____

Occupation : _____

Designation : _____

Office Address: _____

_____

_____ Pin : _____

Contact no.: _____

Mobile no.: _____

Email: _____

Medical History _____

_____

_____

Father's/Guardian's Details:

Name: _____

Residential Address: House number _____

Street _____

Area _____ Landmark _____

City _____ State _____ Pin _____

Contact no. : _____

Qualification : _____

Occupation : _____

Designation : _____

Office Address: _____

_____

_____ Pin : _____

Contact no.: _____

Mobile no.: _____

Email: _____

Medical History _____

_____

_____

Siblings Name (if any)	Gender	Date of Birth	School Attending	Standard

Additional Members in the family:

Name	Gender	Relationship to Child	Date of Birth

MEDICAL HISTORY

todd
Preschool. Activity Center

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: _____

Address: _____

_____

_____ Pin: _____

Home Phone: _____

Mobile No.: _____

E mail ID: _____

Relationship with the child: _____

Name: _____

Address: _____

_____

_____ Pin: _____

Home Phone: _____

Mobile No.: _____

E mail ID: _____

Relationship with the child: _____

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:

_____

_____

_____

todd
Preschool. Activity Center

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 todd 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 todd 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 todd 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