

**2**: +234 806 250 1533, +234 803 411 9769

21 Charles Okeke Street, Alahun Osunba Estate, Mazamaza,

Lagos, Nigeria.

: info@crainbowschools.com.ng

• www.crainbowschools.com.ng

## **REGISTRATION FORM**

Surname:	
First name:	
Middle name:	
Date of Birth: State of Origin:	Gender: M F
Religion:	
Has your child ever been in a school? Yes No {please tick}	
If yes, indicate name of the school attended:	
Reason(s) for leaving the school:	
Father/Guardian's Full Name:	
Address:	
Office Telephone: N	Mobile:
Email Address: O	ccupation:
Mother/Guardian's Full Name:	
Address:	
Office Telephone:	Mobile:
Email Address: O	ccupation:
{Please inform the school immediately; if there is a change of address or phone number}	
Medical Date: Child's Blood Group: Genotype:	
Has the child got any history of convulsion/asthma? Yes No {   {please tick}}	
If yes, how often;	
What type of treatment was given?	
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Was the child given complete doze of immunization? (Please attach a photocopy of the child's immunization schedule)	
Does the child have any Food Allergy: Yes No Drug Allergy: Yes No	
If yes, please list name(s) of food/drugs the child is allergic to;	
Any form of Disability? Yes No {please tick}. If yes, please indicate;	
Signature and date {parent/guardian}:	