

NEW HAVEN S.D.A. EARLY CHILDHOOD CENTRE

REGISTRATION FORM

NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

MOTHER'S NAME: _____

ADDRESS: _____

TELEPHONE #: (H) _____ (W) _____

OCCUPATION: _____

FATHER'S NAME: _____

ADDRESS: _____

TELEPHONE #: (H) _____ (W) _____

OCCUPATION: _____

IN CASE OF EMERGENCY NOTIFY:

NAME: _____

ADDRESS: _____

TELEPHONE #: _____

OR

NAME: _____

ADDRESS: _____

TELEPHONE #: _____

RELIGION: _____

COMMENTS ABOUT CHILD (ALLERGIES, CHILDHOOD ILLNESS, FEARS, NUMBER OF SISTERS AND BROTHERS, ETC.)

FOR OFFICIAL USE ONLY

DATE OF ADMISSION: _____

CLASS ASSIGNED: _____

STATE OF IMMUNIZATION: _____

PREVIOUS SCHOOL ATTENDED: _____