

Return this form to the office of admission  
Excel community school



P.O.Box LG 37, Legon, Accra  
Location: Community 17 Lashibi  
Tel: 0244 671 446 / 0244 317 178



# REGISTRATION FORM

## A. Child Information

Child's Name: \_\_\_\_\_  
Family / Last Name                      First Name                      Middle

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birth Place: \_\_\_\_\_ Gender: \_\_\_\_\_  
Month                      Day                      Year

Anticipating starting date: \_\_\_\_\_ Nationality: \_\_\_\_\_ Religion: \_\_\_\_\_

Home Language (s) \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Previous schools attended (if any): \_\_\_\_\_

Siblings (s):      Number of Brother: \_\_\_\_\_ Ages: \_\_\_\_\_

Number of Sister: \_\_\_\_\_ Ages: \_\_\_\_\_

## B. Family Information

Father's Name: \_\_\_\_\_ Profession: \_\_\_\_\_

Email: Address: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Nationality: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Profession: \_\_\_\_\_

Email: Address: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Nationality: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Residence Address: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

**C. HEALTH INFORMATION** (To be completed by parent or guardian)

Dear parents: This health form is to be provided no later than the child's first day at school along with the application. *(Please attach records to prove immunization)*

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M  F

Date of Birth \_\_\_\_\_ Nationality \_\_\_\_\_  
Month Day Year

Weight at Birth: \_\_\_\_\_ Present Weight: \_\_\_\_\_

Name of family doctor: \_\_\_\_\_ Phone number: \_\_\_\_\_

**Existing Medical Conditions** *(check all that apply)*

**History with any of the following conditions?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Attention-Deficit/ Hyperactivity Disorder        | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Tuberculosis   |
| <input type="checkbox"/> Allergies (if yes, fill allergies section below) | <input type="checkbox"/> Chicken pox    | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Convulsion     | <input type="checkbox"/> Measles        |
| <input type="checkbox"/> Hearing Impairment                               | <input type="checkbox"/> Skin infection |   |
| <input type="checkbox"/> Visual Impairment                                | <input type="checkbox"/> Mumps          |   |
| <input type="checkbox"/> Sickle Cell Disease                              | <input type="checkbox"/> Typhoid fever  |   |

**Record of Immunization (Dates)**

Anti-tuberculosis (BCG) _____	Whooping Cough, Tetanus and Diphtheria
Poliomyelitis (I _____	(i) _____
(ii) _____	(ii) _____
(iii) _____	(iii) _____
	Measles: _____

**D. Emergency Contact Information**

In the event of an emergency contact: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

**E. Allergies**

Allergy to: (specify) food \_\_\_\_\_ medication \_\_\_\_\_

Insect Bite \_\_\_\_\_ other (s) \_\_\_\_\_

Severity of your child's allergic reaction (Tick one):  Mild  Moderate  Severe

Signs of your child's allergic reaction ( Tick all that apply):  Hives  Watery Eyes  
 Wheezing  Coughing  Tightness In The Throat  Difficulty In Breathing

Other signs (describe) \_\_\_\_\_

Does your child have any special need(s) Yes  No

If yes, provide details: \_\_\_\_\_

**F. Undertaking**

The above named child lives with:  Both Parents  Mother  Father  Guardian

I hereby certify that the information on this application is accurate and complete.

I understand that my attendance at School meetings and parent conference is an important factor in my child's development within the

EXCEL COMMUNITY SCHOOL program.

I have agreed to enroll my child and undertake all parental responsibilities

Signed: \_\_\_\_\_  
*(Parent or Legal Guardian)*

Date: \_\_\_\_\_

**G. FOR OFFICIAL USE ONLY**

Registration No: \_\_\_\_\_

Date of Admission: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

Date received at Excel Community School: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY