



# APPIAN WAY SCHOOLS

CRECHE KINDERGARTEN NURSERY  
PRIMARY AFTER SCHOOL SERVICES

Motto: Starting life on the beautiful way.

No. 4 Agbor Ifo Crescent, Off Unity Estate Road,  
Abule-Odu, Lagos  
Tel: 08034811290, 08056072983  
info@appianwayschools.com,  
enquiries@appianwayschools.com  
www.appianwayschools.com

## REGISTRATION FORM

### FORM NO.:

Name of Pupil

Surname

First Name

Middle Name

dd/mm/yy

Sex:

Date of Birth:

Nationality:

State of Origin:

Religion:

Home Address:

Educational History

Previous School Attended:

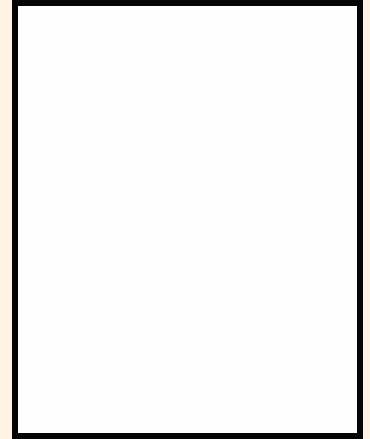
Last Class in Previous School:

**FOR OFFICIAL USE ONLY**

Remark:

Date:

Admission Number:





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## PARENT/GUARDIAN INFORMATION

Parents' Name	Surname	First Name	Middle Name
	Mr.		
	Mrs./Ms		

Home Address:

Mobile Phone No.:

Occupation/Office Address:

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Guardian's Name: Mr.

Mrs./Ms

Relationship to Child:

Home Address:

Mobile Phone No.:

Occupation/Office Address:

## Medical History/ Emergency Contact

Genotype:  Blood Group:

Allergies/Medical Condition (if any):

In case of Emergency, Who do we contact?

Name:

Relationship to Child:

Mobile No.:  Home Phone.:



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## MEDICAL PERSONNEL INFORMATION

Hospital's Name:

Hospital's Phone No.:

Hospital Address:

Medical Insurance No.:   
(if available)

**ADDITIONAL INFORMATION:** Please indicate likes/dislikes, potty training, special interest, etc.:

**IMMUNIZATIONS:** The Federal Ministry of Health requires that we have a photocopy of your child/ward's recent immunization record in our files. Kindly attach a copy of this form.

**EMERGENCY CONSENT:** It's our policy to notify parents/guardian(s) when a child/ward is ill or needs medical attention. Occasionally, if we cannot contact either of both on time and we need to get immediate help for the child/ward, our next procedure is to take appropriate action on behalf of your child/ward.

I/We hereby consent for my child/ward:

**WHEN ILL/INJURED, TO BE TAKEN TO THE NEAREST EMERGENCY CENTRE BY THE STAFF OF MY CHILD/WARD'S SCHOOL WHEN I CANNOT CONTACTED. I FURTHER AGREE TO PAY ALL COST INCURRED IN THE COURSE OF THE EMERGENCY.**

Parent Name:

Signature:

Date:

## Authorized Alternative Pick Up Details

Your child will only be released to the authorized person filled on the form [Parent/Guardian and or Emergency contact]. In case of any unseen circumstance, please indicate the name, address and phone number of any other.

	Name	Address	Phone Number
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>