Shamar Children School

THE BEST BASIC EDUCATIONAL CENTRE

Children are not only taught but reared

Founded September 2003

Government Approved

Welcome, Thank you for choosing our school. It is a government approved school since September 2003.

We are committed to building a total child free from mediocrity, shame and low self-esteem. We are result oriented.

We believe cleanliness is next to Godliness:

* Correct and clean uniforms for different days must be worn and they should have the right hairdo
* Worn out uniforms are not allowed
* Parents Teachers Performance Forum (PTPF) meetings are compulsory for all parents/guardians
* All fees/levies are to be paid before resumption
* All learners must have their books for effective teaching and learning
* Sick children are not to come to school
* Parents are to come early to pick their children to avoid injuries
* Incase of any emergency where parents cannot be reached, the school will act accordingly to ensure the well being of our children
* All school/extra curricular activities are compulsory for all learners
* I will abide by the rules and regulations of the school.

I _____ hereby agree to all the information stated above.

Registration Form

A. CHILD DATA

NAME: _____
(Surname) (Middle Name) (First Name)

DATE OF BIRTH: _____ NATIONALITY: _____ RELIGION: _____

STATE OF ORIGIN: _____ L.G.A _____

CLASS INTENDED: _____ YEARS OF SEEKING ADMISSION: _____

PREVIOUS SCHOOL ATTENDED: _____ PREVIOUS CLASS: _____

CHILD'S HOBBIES: _____

1, Amone Street, Kolokolo Layout, Off Udu Road Enerhen Warri,
Delta State, Nigeria. +2348037090090, 09083783646
shamarfoundation www.shamarfoundation.co

B. PARENTS/GUARDIANS DATA

FATHER'S NAME: _____ MOTHER'S NAME: _____

OCCUPATION: _____ OCCUPATION: _____

PHONE NO.: _____ PHONE NO.: _____

Is anybody (apart from you) authorised to pick your child from school? Yes☐ No☐

if Yes, NAME: _____ SEX: _____

ADDRESS: _____ RELATIONSHIP: _____

Incase of emergency, whom should we contact? _____

ADDRESS: _____ PHONE NO: _____

C. HEALTH DATA

CHILD'S ALLERGIES (if any): _____

IMPAIRMENTS (if any): _____

CHILD'S GENOTYPE: _____ CHILD BLOOD GROUP: _____

NAME /ADDRESS OF FAMILY CLINIC: _____

FAMILY DOCTOR: _____ PHONE NO.: _____

Would you want your child to be immunized in the school? Yes☐ No☐

D. OFFICIAL

NAME (of receiving official/school representative): _____

COMMENTS: _____

CLASS ADMITTED INTO: _____

_____ _____

Signed: Date: