**Early Childhood Development Center**

**Student Admission Record**

**Region 6**

PLACE

PHOTOGRAPH

HERE

REFERENCE NO…………………………………………………….. DATE………..…………

NAME OF ECDC…………………………………………………….. SEX…………………….

NAME OF CHILD…………………………………………………… BIRTH CERTIFICATE NO…………..

RELIGIOUS AFFILIATION……………………………………………………………….

LAST ECDC ATTENDED………………………………………………………………….

REASON FOR LEAVING……………………………………………………………………………………………………………………………….

CLASS PLACED ON ADMISSION…………………………………………. CLASS ON LEAVING……………………………………….

NO. OF SIBLINGS………………………………… PLACE IN FAMILY………………….…. PET NAME………………………………..

MOTHER’S NAME……………………………………………....................................... PHONE NO……………………………….

ADDRESS……………………………………………………………………………………………………………………………………………………

OCCUPATION…………………………………………………………………………………… WORK NO………………………………………

FATHER’S NAME…………………………………………………………………………………….. PHONE NO……………………………….

ADDRESS……………………………………………………………………………………………………………………………………………………

OCCUPATION……………………………………………………………………………………… WORK NO…………………………………..

GUARDIAN’S NAME………………………………………………………………………………… PHONE NO………………………………

ADDRESS……………………………………………………………………………………………………………………………………………………

OCCUPATION……………………………………………………………………………………… WORK NO……………………………………

NAME OF PERSON TO COLLECT CHILD……………………………………………………………………………………………………….

NB (IN CASE OF CHANGE INFORM ECDC IMMEDIATELY)

IN CASE OF AN EMERGENCY, CONTACT ……………………………………………………………………………………………………

ADDRESS………………………………………………………………………………………….. PHONE NO……………………………………

SPECIAL DIETAY REQUIREMENT (IF ANY)……………………………………………………………………………………………………

**MEDICAL INFORMATION**

FAMILY DOCTOR………………………………………………………………………………………… PHONE NO…………………………..

ADDRESS……………………………………………………………………………………………………………………………………………………

HEALTH FACILITY……………………………………………………………………………………………………………………………………….

DOES THE CHILD SUFFER FROM ANY OF TE FOLLOWING? (TICK ALL APPROPRIATE BOXES)

ASTHMA SICKLE CELL DIABETES RHEUMATIC FEVER/ HEART DISEASE ALLERGIES

EPILEPSY

OTHER (PLEASE SPECIY) ………………………………………………………………………………………………………………………..

SPECIAL NOTE……………………………………………………………………………………………………………………………………………

IMMUNIZATION RECORD

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| 1ST | 2ND | 3RD | 4TH | 5TH |
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BCG

OPV/IPV

DT/DTP

MMR

VARICELLA

HEPATITIS B

HIB

PENTAVALENT(DPT, Hep B, HIB)

OTHER

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEAD OF ECDC PARENT/GUARDIAN

DATE…………………………………………… DATE…………………………………………