



Registration Form

Remarks

Membership Details

1 Month	<input type="checkbox"/>	3 Months	<input type="checkbox"/>	4-week	<input type="checkbox"/>	8-week	<input type="checkbox"/>	Other	<input type="text"/>
Baby	<input type="checkbox"/>	Toddler	<input type="checkbox"/>	Preschool	<input type="checkbox"/>	Above 4 years old	<input type="checkbox"/>		<input type="text"/>

Family Name	<input type="text"/>	First Name	<input type="text"/>	Nickname	<input type="text"/>	
Sex	M <input type="checkbox"/>	F <input type="checkbox"/>	Date of Birth	<input type="text"/>	Age	<input type="text"/>
Nationality	<input type="text"/>	First Language Spoken	<input type="text"/>	Other Languages	<input type="text"/>	

Address	<input type="text"/>		
Home No.	<input type="text"/>	Mobile No.	<input type="text"/>
Email	<input type="text"/>	PO Box	<input type="text"/>

Family Information

Father's Name	<input type="text"/>	Mobile No.	<input type="text"/>	Place of work	<input type="text"/>
Mother's Name	<input type="text"/>	Mobile No.	<input type="text"/>	Place of work	<input type="text"/>
Emergency Contact	<input type="text"/>	Relationship to Child	<input type="text"/>		
Address	<input type="text"/>		Contact No.	<input type="text"/>	

Other Information

Medical Consent	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Allergies	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Food Intolerance	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Snack Box	Y	<input type="checkbox"/>	N	<input type="checkbox"/>

Your Child's Favorite Things