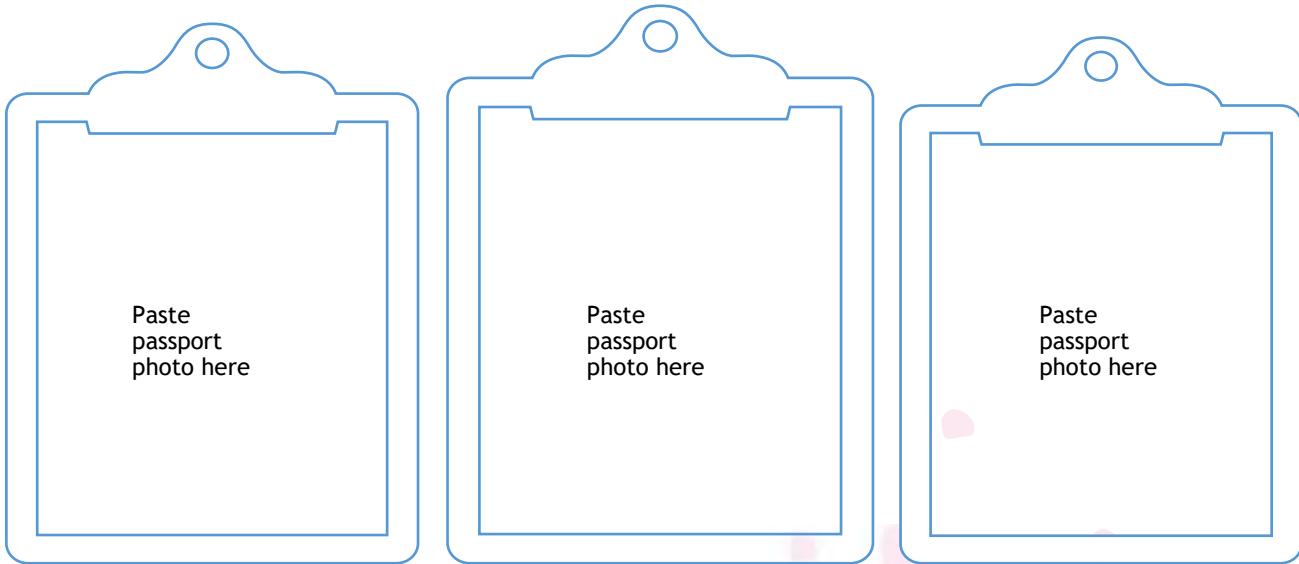




Play, Learn and  
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## ADMISSION FORM

\*Children with special needs will be accepted after evaluation is made to determine whether or not the school can be beneficial to the child's development.

This form must be returned with the following documents:

- Child's birth certificate (certified copy)
- Passport photo of child (to be pasted above.)
- Passport photo of both parent's/guardians or as applicable (pasted above)
- Immunization card.
- Certified copy of ID of both parents/guardians or as applicable.(front and back)
- Certified copy of report card of previous school (s) if applicable.

**Please note that no child will be admitted without ALL the documents.**

**Office:** 0772 166 274

**Director:** 0721 166 274

**Email:** info@brightbeginnings.co.ke

**Website:** www.brightbeginnings.co.ke



## **GENERAL INFORMATION**

CHILD'S NAME: \_\_\_\_\_ NEMIS NO.: \_\_\_\_\_

DATE OF BIRTH: (YYYY/MM/DD) \_\_\_\_\_ GENDER: \_\_\_\_\_

RESIDENCE: \_\_\_\_\_

PREVIOUS SCHOOL ATTENDED \_\_\_\_\_

### **PARENTS OR GUARDIANS**

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ ID NO.: \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

PROFESSION/PLACE OF WORK: \_\_\_\_\_

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ ID NO.: \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

PROFESSION/PLACE OF WORK: \_\_\_\_\_

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### EMERGENCY CONTACT(S)

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

### PERSONS AUTHORISED TO PICK THE CHILD (other than parent/guardian)

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

### PERSONS NOT AUTHORISED TO PICK THE CHILD (WHERE APPLICABLE)

NAME: \_\_\_\_\_ ID: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

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## PARENTS STATUS

MARRIED  SEPARATED  DIVORCED  WIDOWED  SINGLE PARENT

Please tell us more about your child and what you hope for them. What would you like your child to gain from the school?

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## **CONSENT**

- I consent to having Bright Beginnings collect personal information for registration.
- I further consent to the use of information contained in this form and otherwise collected by or on behalf of Bright Beginnings, for purposes of establishing, maintaining and terminating the student or parent's relationship with Bright Beginnings.

I consent to the following:

Photographs and work samples of my child to be used in:  
Yearbooks, Newsletters, Websites, Promotional Material, In-school parent communication

Parent/Guardian Name: .....

Signature: .....

Date: .....

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## HEALTH INFORMATION

CONDITION	YES/NO	COMMENTS
Allergies (Food, Insects, Drugs, latex)		
Allergies (Seasonal)		
Asthma or breathing problems		
Attention Deficit/Hyper Activity Disorder		
Behavioral Problems		
Development Problems		
Bladder problem		
Bleeding problem		
Bowel Problem		
Cerebral Palsy		
Dental Problems		
Head Injury/concussions		
Hearing problems or deafness		
Heart problems		
Muscle problems		
Seizures		
Sickle cell Disease (not trait)		
Speech problems		
Spinal injury		
Surgery		
Vision problems		

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Describe any other important health-related information about your child (e.g. feeding tube, hospitalization, oxygen support, hearing aid, dental appliance.)

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List all prescription, over the counter and herbal medications your child takes regularly.

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Check here if you want to discuss confidential information with the school

Please provide the following information where applicable

	Name	Phone
Pediatrician/Primary Caregiver		
Specialist		
Dentist		
Caseworker		

Child's Health Insurance: \_\_\_\_\_ None: \_\_\_\_\_

Give details:

.....

In the event of an emergency, I allow Bright Beginnings Kindergarten to have my child transported to the local hospital for treatment. I agree to pay for all medical treatment.

Parent/Guardian Name: \_\_\_\_\_ Signature: \_\_\_\_\_

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

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