



PLAY PAEDIATRIC CONSULT

C5, Vista Estate, Igbokusu, Lekki Lagos. Tel: 08075549815, 09018919339, 07088636332
email: info@playpaediatricconsult.com

Registration Form

*Please complete this form in block letters.

SECTION A (Child)

1. Child's Surname _____
2. Child's First Name _____
3. Child's Other Name (s) _____
4. Gender _____
5. Age _____
6. Date of Birth _____
7. Nationality _____
8. State _____
9. Haemoglobin Genotype (if known) _____
10. Blood Group (if known) _____
11. Child's Residential Address

SECTION B (Father)

12. Father's Name _____
(Please include designation)
13. Occupation _____

14. Religion _____

15. Telephone Number(s) _____

16. E-mail Address _____

SECTION C (Mother)

17. Mother's Name _____
(Please include designation)

18. Occupation _____

19. Religion _____

20. Telephone Number(s) _____

21. E-mail Address _____

NB: Section D should only be filled if the child lives with anyone other than either of the biological parents.

SECTION D (Guardian)

22. Name of Guardian _____
(Please include designation)

23. Occupation _____

24. Relationship to Child _____

25. Is the child adopted? Yes No

(If yes, please attach copies of relevant legal and/or other related documents)

26. Telephone Numbers _____

27. E-mail Address _____

28. For how long has the child been living with you? _____

SECTION E

DECLARATION

I, _____, the _____
(Name of Parent /Guardian filling the form)

of _____ hereby declare that
(Name of Child being registered)

the entire information given in this form is correct.

.....
**Signature of Parent/Guardian
& Date**

.....
Doctor's Signature & Date

NB: Please append your signature on the topmost right corner of every page of this registration from.

<p style="text-align: center;">For Office Use Only</p> <p>File Number.....</p> <p>Date of Registration.....</p> <p>Contact Phone Number(s).....</p> <p>.....</p>
