HEARTFRIENDS STUDENT CARE CENTRE

Blk 3 Dover Road #01-354 Singapore 130003 Tel: 67764906
Email: info.hscc@sjsm.org.sg

REGISTRATION FORM

1. CHILD'S PARTICULARS

Name (as in birth cert.)				
Chinese Characters (if applicable)			**Gender**	☐ Male ☐ Female
Birth cert no. / FIN no.			**Citizenship**	
Date of Birth (dd/mm/yy)			**Race**	
Birth Order			**No. of Sibilings**	
First language spoken at home	☐ English ☐ Malay ☐ Mandarin ☐ Tamil ☐ Others:			
Religion	☐ Buddhism ☐ Christianity ☐ Hinduism ☐ Islam ☐ Others:			
Address			**Tel No.** (home)	
Name of School				
Name of Form Teacher			**Level & Class in 20____**	

After School Activities	Day	Time	Duration	Activity (e.g. tuition, CCA, remedial)

Authorised Persons	The following persons are authorised to fetch my child from BASC			
	Name	Relationship	NRIC No.	Contact No.

2. PARENTS'/ GUARDIAN'S PARTICULARS

	Father/ Guardian	Mother/ Guardian
Name		
Citizenship		
Occupation		
Name of Company		
Gross Monthly Income		
Tel No. (office)		
Mobile No.	☐ *Please tick on a preferred contact for emergency SMS*	☐
Email Address		
Religion	Buddhism / Christianity / Hinduism / Islam / Others:	Buddhism / Christianity / Hinduism/ Islam / Others:
Highest Academic Qualification		
Marital Status	☐ Married ☐ Single ☐ Divorced ☐ Widowed	
If you are divorced or a single parent	Name of parent with custody:	
	Is the other parent authorised to fetch the child from school	☐ Yes ☐ No
If your child is adopted	Has your child been told?	☐ Yes ☐ No

3. IN CASE OF EMERGENCY, PLEASE CONTACT					
Name of Person		**Contact No**		**Relationship to Child**	

4. CHILD'S MEDICAL HISTORY (*Please attach details where necessary*)					
Has your child had	☐ Hepetitis	☐ Mumps	☐ Measles	☐ Diabetes	☐ Chicken Pox
Does your child have	☐ Congenital Heart Disease		☐ Asthma	☐ Epileptic Fits	
Is your child prone to:	☐ Colds	☐ Tosilitis	☐ Ear Aches	☐ Vomitting	☐ Stomaches

Does your child have any allergies? If yes, please describe.	
Does your child have any health problems? If yes, please elaborate or attach medical report.	
Does your child have any special needs? If yes, please elaborate or attach medical report.	
Is there any food or drink that your child is not allowed to consume? If yes, please describe.	
Is there anything else about your child that the school should be aware of? If yes, please describe.	

5. CHILD'S MEDICAL RECORDS			
Child's Doctor's Name		Clinic Name	
Clinic Address		Clinic Tel No.	

6. REQUIREMENTS

1. Copy of child's birth certificate.
2. Copy of child's passport/ visit pass/ dependent's pass/ student pass (for non-Singaporean)
3. Copy of parents' identity cards / reentry permit / passport.
4. Non-refundable S$50 registration fee + $340 deposit
5. CDA/ Giro Application form.

AGREEMENT

By submitting all personal data listed on the form, you consent to Heartfriends BASC collecting, using, disclosing and/or processing your personal data for the purpose of your child's registration with the student care and when your child has been successfully enrolled in the student care. Such personal data includes information abou tyou and your family as set out in the registration form and documents and any other personal information you have provided.

I have read the Student Care Handbook and agree to abide by the rules, regulations, programme and requirements of Heartfriends BASC.

Name of Father/ Mother/ Guardian **Signature & date**

FOR BASC USE ONLY

Commencing On:		Received By:	
Amount of Fees Paid:		Date:	
Remarks:			

S/No.	Fees Paid	Receipt No.	Date
1	Registration S$50 (non-refundable)		
2	Deposit S$340 (refundable upon 1 calendar month's notice when withdrawing)		
3	Fee for 1st month S$340		