



C.Year		N.Year		Student ID		Receipt No.	
<b>Student Registration Form استمارة تسجيل AY 2026-2027</b>							

<b>Please fill the form correctly and completely:</b>									
Name - الأسم:		Date of birth - تاريخ الميلاد:							
Current Address العنوان الحالي :									
Passport No.: رقم الجواز		Passport Expiry Date:		Nationality: الجنسية					
CPR No.: رقم البطاقة السكانية		CPR Expiry Date:		Sex: الحالة					
Religion - الديانة:		<input type="radio"/> Islam مسلم		<input type="radio"/> Christian مسيحي		<input type="radio"/> Other أخرى			
E-mail Address: عنوان البريد الالكتروني		SMS No.: رقم الرسائل		Home No.: رقم الهاتف					
Parents Home Status: الحالة الاجتماعية للآباء		<input type="radio"/> Married - متزوجين		<input type="radio"/> Parents Separated - الآباء منفصلون		<input type="radio"/> Mother Or Father Deceased - الأم - الاب متوفاة			
Select the Arabic subjects you would NOT like your child to be enrolled (For non-Bahraini students only).		<input type="checkbox"/> Arabic اللغة العربية		<input type="checkbox"/> Bahraini Citizenship مواطنة		<input type="checkbox"/> Islamic التربية الاسلامية			
Father's Name أسم الأب									
Father's Mobile رقم هاتف الأب		Occupation المهنة		Company Name اسم الشركة		Office No. رقم هاتف المكتب		Educational level: <input type="checkbox"/> High School ثانوي <input type="checkbox"/> Diploma دبلوم <input type="checkbox"/> Bachelor بكالوريوس <input type="checkbox"/> Masters ماجستير <input type="checkbox"/> PHD دكتوراه	
Mother's Name أسم الأم									
Mother's Mobile رقم هاتف الأم		Occupation المهنة		Company Name اسم الشركة		Office No. رقم هاتف المكتب		Educational level: <input type="checkbox"/> High School ثانوي <input type="checkbox"/> Diploma دبلوم <input type="checkbox"/> Bachelor بكالوريوس <input type="checkbox"/> Masters ماجستير <input type="checkbox"/> PHD دكتوراه	
Name of brothers - Sisters in the school أسماء الإخوة - الخوات الملتحقين بالمدرسة						Year الصف			
What level do you intend to enroll: الصف الملتحق به: <input type="checkbox"/> Nursery حضانة <input type="checkbox"/> Reception <input type="checkbox"/> Year 1 <input type="checkbox"/> Year 2 <input type="checkbox"/> Year 3 <input type="checkbox"/> Year 4 <input type="checkbox"/> Year 5 <input type="checkbox"/> Year 6 <input type="checkbox"/> Year7 <input type="checkbox"/> Year8 <input type="checkbox"/> Year9 <input type="checkbox"/> Year10									
I certify that the information contained herein is correct to the best of my knowledge, any falsification made into this is subject to disciplinary action. اتعهد بأن جميع البيانات المذكورة أعلاه صحيحة و مطابقة للواقع،و أي أخلال في ما سبق قد يؤدي إلى إلغاء تسجيل أبنّي/أبنتي في المدرسة.									
Parent Name -----		Parent Signature -----		Date -----		HOA Signature -----			



### MEDICAL CONSENT FORM

Is your child allergic to any medication, food, or product?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes .....
Is your child taking any regular medication or is he/she is receiving regular treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes .....
Has your child had any illness or injury requiring hospitalization or an operation?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes .....
Does your child have any specific emotional or psychological problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes .....
Does your child have any specific behavioral problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes .....
Does your child have any problems with eyesight, or does he/she wear glasses?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes .....
Does your child have any hearing or hearing related problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes .....
Does your child have any specific physical disability?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes .....
Does your child have any chronic illness (sickle cells, diabetes, hypertension, G6BD, heart disease...etc.)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes .....
Does your child have epilepsy/seizure problem?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes .....

I Parent of (\_\_\_\_\_) in class (\_\_\_\_\_) agree that the school nurse has the permission to administer medication if my child becomes ill during his/her day at school along with my permission. In all instances, a note will be sent home with the child stating the dosage, amount given and the time it was given.

If your child has any medication to be taken during school hours, please give it to the school nurse with your child medication that has been prescribed by your doctor during school hours, you must send the child with a written note, giving the name of the medication, the reason for administration, dosage and times to be given, as well as a contact number where you can be reached on that day / week. Please ensure that the school has the nominated emergency contact details. Without this note, any medication brought to the school by your child cannot be administered.

Please notify the school nurse immediately if your child has contacted any communicable diseases and / or if you notice any changes in your child's overall health. This will help us to ensure that the health of your child and others in the school community is paramount.

#### Description:

Parent's name (print): \_\_\_\_\_ Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_