

SIBLINGS

NAME	SCHOOL ATTENDED	AGE
1		
2		
3		
4		

MISCELLANEOUS

HOW DID YOU HEAR ABOUT THE POTTERS LAND SCHOOL?

NEWSPAPER ☐ WEBSITE ☐ SOCIAL MEDIA ☐

WORD OF MOUTH/REFERRAL
(Please state name and Phone No)

OTHER (please specify)

DECLARATION

I/We request that our above named child be enrolled as a prospective pupil. I/We understand that the terms and conditions of the school will undergo reasonable changes from time to time as circumstances demand and will apply in our relations with the school. I/We understand that the school may obtain, process and hold personal data about our child including medical information and we consent to this for the purpose of evaluation and, if a place is offered, in order to protect and promote the welfare of our child.

X Father's Signature & Date X Mother's Signature & Date

ENCLOSURES

Please return the duly completed form with the following documents and note that the originals will be required for sighting:

- 1. Birth certificate
- 2. Immunization Record
- 3. Previous term's school report
- 4. Transfer certificate or transcript (where applicable)
- 5. Two (2) recent Passport photograph of child
- 6. One (1) recent Passport photograph of each parent.

FOR OFFICIAL USE ONLY

Date Received: / / Date of Assessments: / /

Remarks:

Offer Admission? Yes No

Name: Signature:

Headteacher's Signature: Date

Please notify the school of any change to the information provided via info@potterslandschool.com



ADMISSION FORM

SURNAME:

OTHER NAMES:

REGISTRATION No:

DATE OF ENROLMENT:



Dreamworld Africana Way
KM 20, Lekki-Epe Expressway
Lekki, Lagos
t: 0909 040 6699
e: info@potterslandschool.com
w:www.potterslandschool.com

CHILD’S INFORMATION

SURNAME

FIRST NAME

OTHER NAMES

WHAT DO WE CALL HIM/HER?

GENDER: MALE

FEMALE

DATE OF BIRTH:

PLACE OF BIRTH

COUNTRY OF BIRTH

NATIONALITY

STATE OF ORIGIN (If Nigerian)

RELIGION

ETHNICITY

FIRST LANGUAGE

OTHER LANGUAGES

PREVIOUS SCHOOLS ATTENDED (where applicable)

1.

PRESENT SCHOOL

CLASS

ADDRESS

2.

NAME

CLASS

ADDRESS

HEALTH/MEDICAL HISTORY

BLOOD GROUP

GENOTYPE

ANY KNOWN DISABILITY/ALLERGY? YES

NO

IF YES, STATE

OTHERS (Please specify)

SPECIAL INSTRUCTION FOR MEDICAL CARE

AFFIX
CHILD'S PASSPORT
PHOTOGRAPH
HERE

FAMILY INFORMATION

NATURE OF FAMILY (please tick)

NUMBER OF SIBLINGS

SINGLE PARENT

MONOGAMOUS

DIVORCED

SEPARATED

POLYGAMOUS

FATHER

NAME

DATE OF BIRTH

NATIONALITY

OCCUPATION

COMPANY NAME AND ADDRESS

DESIGNATION

TELEPHONE

RESIDENTIAL ADDRESS

TELEPHONE

PREFERRED EMAIL

MOTHER

NAME

DATE OF BIRTH

NATIONALITY

OCCUPATION

COMPANY NAME AND ADDRESS

DESIGNATION

TELEPHONE

RESIDENTIAL ADDRESS

TELEPHONE

E-MAIL

EMERGENCY CONTACT

NAME

RELATIONSHIP TO STUDENT

RESIDENTIAL ADDRESS

TELEPHONE

E-MAIL