

## 1. STUDENT DETAILS:

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

DATE OF BIRTH: \_\_\_\_\_ HOSPITAL: \_\_\_\_\_

GENDER: \_\_\_\_\_ AGE: \_\_\_\_\_

TRIBE: \_\_\_\_\_ NATIONALITY: \_\_\_\_\_

RELIGION: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

CLASS APPLIED: \_\_\_\_\_

Student  
Photo



# UP SKILL ACADEMY

## DAY CARE, NURSERY AND PRIMARY SCHOOL



Learn together.....Archieve together

**Contacts: +255 777903231 & +255 772217921**  
**MAUNGANI VIJINI, ZANZIBAR - TZ**

**Email: upskillacademy81@gmail.com**  
**P.O.BOX 60**

## PRIMARY REGISTRATION FORM

NAME OF PREVIOUS SCHOOL: \_\_\_\_\_

## 2. PARENTING/GUADIAN DETAILS

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

MOBILE NO: \_\_\_\_\_

Email: \_\_\_\_\_

NATIONALITY: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

.....

.....

DATE

SIGNATURE

### 3. SPONSOR'S DETAILS

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

MOBILE NO: \_\_\_\_\_

EMAIL: \_\_\_\_\_

NATIONALITY: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE

SIGNATURE

### 4. CURRENT MEDICAL INFORMATION

Child's Health Insurance Identification Card Number: \_\_\_\_\_

Name of child's Physician: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

My child's has allergies: No \_\_\_\_\_ Unknown \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please list the allergies: \_\_\_\_\_

#### Please comment on

Condition that your child has that require (s) medical attention – such as diabetes, epilepsy, asthma etc.

\_\_\_\_\_  
\_\_\_\_\_

Physical activity restrictions: \_\_\_\_\_

Hearing or vision problem that cannot be corrected: \_\_\_\_\_

\_\_\_\_\_

Your child's previous history of communicable diseases (eg: Chicken Pox, Measles)

\_\_\_\_\_

Other conditions that may require a teacher to take action for the benefit of your child's health:

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## 5. PERMISSION FOR MEDICAL TREATMENT

In the event of an accident or illness involving my child while my child is in care of Up Skill Academy. I hereby authorize the administration of any medical procedure deemed necessary, including anesthetic, by the above named Doctor, or any hospital Emergency Department, or by any qualified physician. In no case will the staff or the center be financially liable to costs incurred as a result of emergency procedures undertaken.

Signature: \_\_\_\_\_

## 6. EMERGENCY CONTACT (in the event of an emergency)

### Contact Person #1

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Contact Person #2

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Contact Person #3

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## 7. FEE STRUCTURE **TZS 1,050,000/**

| S/N                | PARTICULAR        | COST                    |
|--------------------|-------------------|-------------------------|
| 1.                 | Full Registration | Tsh: 100,000/=          |
| 2.                 | Uniform           | Tsh: 80,000/=           |
| 3                  | Stationery        | Tsh: 60,000/=           |
| 4.                 | School Fee        | Tsh: 600,000/=          |
| 5.                 | Full Meals        | Tsh: 360,000/=          |
| <b>GRAND TOTAL</b> |                   | <b>Tsh: 1,200,000/=</b> |

### Note

**TZS 150,000/**

Note: For all those who will require the half meal service, they will pay TZS 150,000/= which corresponds to a total of TZS 1,050,000/= per year.

### OTHER PAYMENTS

Transport = Tsh: 400,000/=

Study Tour = Tsh: 50,000/=

## 8. MODE OF PAYMENT

1. Payment should be done through approved School Account.

| NAME OF BANK | ACCOUNT NUMBER | ACCOUNT NAME      |
|--------------|----------------|-------------------|
| EQUITY BANK  | 3014111817943  | RADHIA SEIF SALUM |

2. Payment should be done in two or three installments.

3. Uniform, Registration, and Stationery – **TZS 240,000/** (This payment should be made before the start of classes).

4. Payment should be done accordingly.

## 9. FULL PAYMENT INSTALLMENT

| INSTALLMENT PERIOD                  | AMOUNT         |
|-------------------------------------|----------------|
| FIRST INSTALLMENT (JANUARY – APRIL) | TSH: 320,000/= |

|  |                |
|--|----------------|
| SECOND INSTALLMENT (MAY – AUGUST)        | TSH: 320,000/= |
| THIRD INSTALLMENT (SEPTEMBER – DECEMBER) | TSH: 320,000/= |

## 10. HALF PAYMENT INSTALLMENT

| INSTALLMENT PERIOD                       | AMOUNT         |
|--|----------------|
| FIRST INSTALLMENT (JANUARY – APRIL)      | TSH: 270,000/= |
| SECOND INSTALLMENT (MAY – AUGUST)        | TSH: 270,000/= |
| THIRD INSTALLMENT (SEPTEMBER – DECEMBER) | TSH: 270,000/= |

## 11. REGISTRATION REQUIREMENT

To register your child the school requires:1. A

completed Application for Admission.

2. A copy of your child's birth certificate or passport as proof of age.
3. Four recent passport size photo.
4. An enrollment payment of fees as outlined below
5. Any progress reports or educational assessment that are available.

## 12. SCHOOL RULES

1. Students are required to arrive at 7:30 am and leaving at 3:30 pm.
2. All students are required to wear proper school uniform.
3. Students should attend all days that school will be open, and if there is any reason that cause not attend, the parent or guardian should contact to class teacher or head teacher of school.

**Note:**

As parent(s)/guardian(s), we would like to enroll our child at Up Skill Academic in the program indicated on this application.

\_\_\_\_\_  
Name of Parent/Guardian

\_\_\_\_\_  
Signature

### 13. FOR OFFICE USE ONLY

Student Registration Number: \_\_\_\_\_

Class started: \_\_\_\_\_ Date Registered: \_\_\_\_\_

Registered by: \_\_\_\_\_ Date: \_\_\_\_\_

HEAD OF SCHOOL: \_\_\_\_\_