GET TEST CONFIDENT

HELPING SCHOOL CHILDREN BEAT TEST ANXIETY

PLEASE COMPLETE ALL SECTIONS OF THIS APPLICATION FORM

Child's Name (in full): _____ Age: _____

Child's Address:_____

_____DOB: _____

Child's First Language Spoken at Home:_____

School Child attends _____Current School Year_____

Parents/Guardians Name: _____

Contact No: _____

Names of Legal Contacts (if different to parents): _____

Address of legal contact (if different to above):_____

_____

E-mail address:_____

Emergency Contact Name: _____

Emergency No: _____

Doctor's Name:_____Doctor's Phone No. _____

Password for signing child out: _____

Special Needs: _____

Any other info: _____