Admission form

School name
Contact details

Child Photo

PERSONAL DATA

CHILD'S NAME:
_____

DATE OF BIRTH; _____/_____/_____**AGE**: _____**YRS** _____**Months**
SEX: M☐ F☐

ADDRESS:

_____

_____

TELEPHONE NO.: _____

NAME OF PARENT/GUARDIAN:
_____

ADDRESS: (H)
_____

ADDRESS: (W)
_____

TELEPHONE NO: (W) _____ **(H)** _____

(Cell) _____

1. EMERGENCY CONTACT INFORMATION **(other than parent/guardian)**

NAME: _____ RELATION: _____

TEL. NO: _____

ADDRESS:
_____

2. EMERGENCY CONTACT INFORMATION **(other than parent/guardian)**

NAME: _____ **RELATION**: _____

TEL. NO: _____

ADDRESS:

_____

Names of person to collect child:

1. **NAME**: _____ **RELATION**: _____

   TEL. NO: _____

   ADDRESS: _____

2. **NAME**: _____ **RELATION**: _____

   TEL. NO: _____

   ADDRESS: _____

STATE DIETARY REQUIREMENT (IF ANY) _____

FAMILY DOCTOR/HEALTH CLINIC: _____

ADDRESS: _____

TEL. NO: _____

Medical History

Please respond by putting a tick ( ) under the appropriate column and record dates of last treatment and remarks for positive responses.

Has your child ever been diagnosed or treated for any of the following conditions?

Past History	Yes	No	Date(S)	Remarks
❖ Asthma	( )	( )		
❖ Bronchitis	( )	( )		
❖ Tuberculosis (TB)	( )	( )		
❖ Disorders of the Ears/Nose/Throat	( )	( )		
❖ Rheumatic Fever/RH. Heart Disease	( )	( )		
❖ Heart Disease	( )	( )		
❖ Epilepsy (Fits)	( )	( )		
❖ Mental Disorders	( )	( )		
❖ Learning Disability	( )	( )		
❖ Physical Disability	( )	( )		
❖ Disorders Of The Kidney/Bladder	( )	( )		
❖ Disorders Of Stomach/Bowels	( )	( )		
❖ Sickle Cell Trait/Disease	( )	( )		
❖ High Blood Pressure	( )	( )		
❖ Diabetes Mellitus (Sugar)	( )	( )		
❖ Leukemia/Lymphoma	( )	( )		
❖ Typhoid	( )	( )		
❖ Headaches	( )	( )		
❖ Anaemia (Week Blood)	( )	( )		
❖ Fainting Spells/Giddiness	( )	( )		
❖ Excess Tiredness	( )	( )		
❖ Visual Disorders	( )	( )		
❖ Hepatitis B	( )	( )		
❖ Meningitis	( )	( )		
❖ Allergies to Medication	( )	( )		
❖ List Other Condition	( )	( )		

Has your child ever been admitted to hospital or had surgery? Yes ☐ No ☐

If yes, please explain for what reason._____

_____

Regular medications taken (if any):

_____

Family History

Has any family member been diagnosed with the following?

	Yes	No	Date(S)	Remarks
❖ Asthma	( )	( )		
❖ Allergies	( )	( )		
❖ Diabetes Mellitus	( )	( )		
❖ Tuberculosis	( )	( )		
❖ Cancer/Tumours	( )	( )		
❖ Sickle Cell Disease	( )	( )		
❖ Mental Disorder	( )	( )		
❖ Heart Disease	( )	( )		
❖ Migraine	( )	( )		
❖ High Blood Pressure	( )	( )		

I certify that the above information is correct.

Signature: _____ date: _____
(Parent/Guardian)