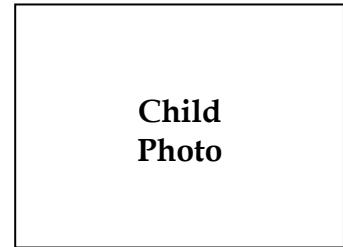


**Admission form**

School name  
Contact details



**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 (Weak 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)