



AHLIA SCHOOL APPLICATION FORM

Office Use: Assessment Date: _____ Time: _____

Student's
Recent Photo

General Information	Family Name: _____ First Name: _____ Middle Name: _____					
	Preferred Name/Nickname: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female					
	DOB: / / Place of birth: _____					
	Nationality: (according to passport) _____ CPR No.: _____					
	Natural Language (mother tongue language) _____					
Applying for grade:	<input type="checkbox"/> 3 yrs Nursery	<input type="checkbox"/> 4 yrs KG1	<input type="checkbox"/> 5 yrs KG2	<input type="checkbox"/> Elementary 1 - 2 - 3 - 4 - 5	<input type="checkbox"/> Middle School 6 - 7 - 8	<input type="checkbox"/> High School 9 - 10
Toilet Trained:	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Previous School's Name:	_____					

Address	House: _____ Flat: _____ Road: _____ Block: _____ Area: _____
	Building/ Compound: _____

Siblings & Relatives	<i>Complete siblings & other adults living with the child in the same house (grandparents, house maids...)</i>	
	Relationship	Name

Student's Interest & Hobbies	<input type="checkbox"/> Reading Specify _____
	<input type="checkbox"/> Sport Specify _____
	<input type="checkbox"/> Arts Specify _____
	<input type="checkbox"/> Music Specify _____
	<input type="checkbox"/> Drama Specify _____
	<input type="checkbox"/> Others Specify _____

Area of Special Needs	<input type="checkbox"/> Speech & Language Specify _____
	<input type="checkbox"/> Fine Motor (use of fingers) Specify _____
	<input type="checkbox"/> Large Motor (use of whole body) Specify _____
	<input type="checkbox"/> Interacting & Dealing with others Specify _____
	<input type="checkbox"/> Attention & Concentration Specify _____
Please Specify in details the child's challenges & actions taken so far:	



Father	Family Name: _____ First Name: _____ Middle Name: _____
	Nationality: _____ Marital Status: Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/>
	Level of Education: (BA, MA, ETC): _____ Occupation: _____
	Mobile: _____ Home/Office: _____
	E-mail: _____

Mother	Family Name: _____ First Name: _____ Middle Name: _____
	Nationality: _____ Marital Status: Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/>
	Level of Education: (BA, MA, ETC): _____ Occupation: _____
	Mobile: _____ Home/Office: _____
	E-mail: _____

Other Guardians (if applicable)	Family Name: _____ First Name: _____ Middle Name: _____
	Nationality: _____ Marital Status: Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/>
	Level of Education: (BA, MA, ETC): _____ Occupation: _____
	Mobile: _____ Home/Office: _____
	E-mail: _____

Emergency Info	Please fill the form below, in case of any emergency when parents or guardians can't be reached:			
	FULL NAME	TEL# 1	TEL# 2	RELATIONSHIP TO THE CHILD

I hereby certify that all information I have provided here is true. Any information found false or incorrect will disqualify my child from being enrolled at Ahlia School, without any financial or legal obligations.

Guardian Name: _____ **Signature:** _____
Date: ____ / ____ / ____

For office use only:

	Application Form
	Student's ID or CPR (copy)
	Parents CPR (copy)
	Birth Certificate (copy)
	Vaccination Certificate (copy)
	Previous Report Cards or Certificates (copy)
	(4) Photos 2x2 in.

Stamp

Checked by: _____

Health History Report

Family Name: _____ **First Name** _____ **Middle Name:** _____

This information is to be completed and signed by parents and returned to the homeroom teacher. It will then be placed on file in the Clinic. The information will be kept in complete confidence.

1. Does your child generally seem to be in good health?

2. Do you believe that your child can participate in regular physical education classes? **Yes** [] **No** []
3.
 - a) Is your child currently taking any kind of medication?

 - b) If so, what kind?

 - c) For what purpose?

4.
 - a) Is your child allergic to any kind of medication or foods? **YES** [] **NO** []
 - b) If so, please specify.

Please circle below any of the following condition/conditions that your child may have.

Skin Disease	Asthma	Convulsive Seizures	Diabetes
G6 PD	Hemophilia	Heart Problems	Hearing Defects
Epistaxis	Sickle Cell Disease	Speech Problems	Vision Defects
Sinus Conditions	Thalassemia	Allergies(ex.): _____	

5. Can the school administer (Panadol) to your child in the event of a headache or fever? **YES** [] **NO** []

Please indicate below emergency contact numbers in the event that we need to reach you.

(Please provide at least 3 Telephone Numbers.)

	Name	Phone Number
Father's		
Mother's		
Other		

Thank you for your cooperation.

Parent's Signature: _____

Ahlia School Nurse: _____