

APPLICATION FORM

For office use only:

Student ID: _____ Assessment Date: _____ Time: _____

Student's & Parents Smart Card reader	Birth Certificate & Vaccination Certificate (copy)	Previous Report Cards (copy)	(4) Photos 2x2 in.
Application Fees	Registration Fees	Book Fees	

General Information	First Name: _____ Middle Name: _____ Family Name: _____					
	Preferred Name/Nickname: _____ Male <input type="checkbox"/> Female <input type="checkbox"/>					
	DOB: / / Place of birth: _____					
	Nationality: (according to passport) _____ CPR No.: _____					
	Natural Language (mother tongue language) _____					
	Applying for grade:					
<table border="1" style="width: 100%; text-align: center;"> <tr> <td>3 years Nursery</td> <td>4 years KG1</td> <td>5 years KG2</td> <td>Elementary 1 - 2 - 3 - 4 - 5</td> <td>Middle School 6 - 7 - 8</td> <td>High School 9 - 10 - 11 - 12</td> </tr> </table>	3 years Nursery	4 years KG1	5 years KG2	Elementary 1 - 2 - 3 - 4 - 5	Middle School 6 - 7 - 8	High School 9 - 10 - 11 - 12
3 years Nursery	4 years KG1	5 years KG2	Elementary 1 - 2 - 3 - 4 - 5	Middle School 6 - 7 - 8	High School 9 - 10 - 11 - 12	
No. Siblings: _____						
Previous School's Name: _____						
Address: House: _____ Flat: _____ Road: _____ Block: _____ Area: _____						

Father	First Name: _____ Middle Name: _____ Family 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	First Name: _____ Middle Name: _____ Family 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)	First Name: _____ Middle Name: _____ Family 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: _____

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:** ___ / ___ / ___



Health History Report

First Name: _____ Middle Name _____ Family 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	Sickle Cell Trait	Heart Problems	Hearing Defects
Epistaxis (nose bleeding)	Sickle Cell Disease	Speech Problems	Vision Defects
Sinus Conditions	Thalassemia	Allergies(ex.): _____	

5. Does your child use any of the devices listed below?
- Medical Glasses Wheel Chair Hearing Aids Other _____

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: _____