

Date: ____/____/____



ALADUMO

INTERNATIONAL HIGH SCHOOL

SURNAME OF STUDENT

FIRST NAME

OTHER NAMES

ADMISSION NUMBER

ADMISSION YEAR



ADMISSION ACCEPTANCE / ACKNOWLEDGMENT FORM

I, _____
(SURNAME OF PARENT/GUARDIAN)

(FIRST NAME)

(OTHER NAME(S))

HOME ADDRESS _____

OFFICE ADDRESS _____

PHONE NUMBER (OFFICE) _____ MOBILE NUMBER _____

I ACCEPT

I DO NOT ACCEPT

THE OFFER OF ADMISSION AWARDED TO

NAME OF CANDIDATE _____
(SURNAME)

(FIRST NAME)

(OTHER NAME(S))

I HEREBY DECLARE THAT I AGREE WITH THE TERMS AND CONDITIONS OF THE ENROLMENT AT ALADUMO INTERNATIONAL HIGH SCHOOL AS STIPULATED IN THE SCHOOL PROSPECTUS / RULES AND REGULATIONS. I AGREE TO ABIDE FULLY BY THE SCHOOL RULES AND I WILL ENCOURAGE MY / OUR CHILD(REN) TO DO SO AS WE SUPPORT FULLY THE SCHOOL'S DRIVE FOR GOOD DISCIPLINE AND ACADEMIC ACHIEVEMENT. ALL PARENTS, GUARDIANS, LEGAL REPRESENTATIVES, STAFF AND CONCERNED STAKEHOLDERS ARE ENCOURAGED TO PROCURE A COPY OF THE STUDENTS' HANDBOOK FOR PERSONAL USE.

(PARENT'S / GUARDIAN'S SIGNATURE)

DATE

GUARDIAN'S DETAILS

Fix Guardian's
Passport Photo
Here

Fix Guardian's
Passport Photo
Here

I, _____
(SURNAME) (FIRST NAME) (OTHER NAME)

(GUARDIAN'S RESIDENTIAL ADDRESS)

(GUARDIAN'S MAILING ADDRESS)

(GUARDIAN'S CORRECT EMAIL ADDRESS IN LOWER CASE (SMALL LETTERS))

(GUARDIAN'S PHONE CONTACT)

(GUARDIAN'S OCCUPATION)

IDENTIFICATION TYPE _____
(DRIVERS' LICENSE / INTERNATIONAL PASSPORT / OFFICE I.D.)

IDENTIFICATION TYPE NUMBER _____
(DRIVERS' LICENSE / INTERNATIONAL PASSPORT NUMBER / OFFICE I.D.)

**NOTE: THE GUARDIAN ACTS IN PLACE OF THE PARENT OF A STUDENT.
PLEASE ENSURE THAT THE GUARDIAN'S NAME IS THE NAME ON THE STUDENT'S MEDICAL FORM.
A STUDENT MAY HAVE MORE THAN ONE GUARDIAN, BUT NOT MORE THAN TWO.**

(PARENT'S SIGNATURE)

DATE

ALL PARENTS, GUARDIANS, LEGAL REPRESENTATIVES, STAFF AND CONCERNED STAKEHOLDERS ARE ENCOURAGED TO
PROCURE A COPY OF THE STUDENTS' HANDBOOK FOR PERSONAL USE.



PERSON AUTHORISED
TO PICK UP STUDENT

Fix Student's
Passport Photo
Here

Fix Authorized
Person's
Passport Photo
Here

I, _____
(NAME OF PARENT / GUARDIAN)

(PARENT'S MOBILE NUMBER / CORRECT EMAIL ADDRESS IN LOWER CASE (SMALL LETTERS))

(NAME OF STUDENT) (CLASS)

STATE BELOW THE NAME OF THE PERSON AUTHORISED BY YOU TO PICK UP YOUR CHILD / WARD

(SURNAME) (FIRST NAME) (OTHER NAME)

KINDLY ENSURE THAT THE PERSON HAS A MEANS OF PERSONAL IDENTIFICATION

IDENTIFICATION TYPE _____
(DRIVERS' LICENSE / INTERNATIONAL PASSPORT / OFFICE I.D.)

IDENTIFICATION TYPE NUMBER _____
(DRIVERS' LICENSE / INTERNATIONAL PASSPORT NUMBER / OFFICE I.D.)

(PARENT'S NAME & SIGNATURE)

DATE



PARENT'S CONSENT / UNDERTAKING

(NAME OF PARENT / GUARDIAN)

(FIRST NAME) (OTHER NAME(S))

(PHONE NUMBER (HOME)) (PHONE NUMBER (WORK))

(STUDENT'S FIRST NAME) (OTHER NAME) (RELATIONSHIP TO STUDENT)

I HEREBY CONSENT AND UNDERTAKE TO FULFIL THE FOLLOWING CONDIITONS IN THE COURSE OF MY CHILD'S EDUCATION AT ALADUMO INTERNATIONAL HIGH SCHOOL.

1. I SHALL PAY HIS / HER FEES PROMPTLY ON OR BEFORE THE AGREED / STIPULATED DATE.
2. I PROMISE TO COMPENSATE THE SCHOOL FOR ANY LOSS OR DAMAGE TO SCHOOL PROPERTY BROUGHT ABOUT BY THE ACTION OF MY CHILD.
3. I SHALL REIMBURSE THE SCHOOL FOR MEDICAL EXPENSES INCURED BY MY CHILD IN REFERRED CASES BY THE SCHOOL NURSE.
4. I HEREBY GRANT PERMISSION TO MY CHILD / WARD TO ATTEND PROGRAMMES AND EXTRA-CURRICULAR ACTIVITIES OF ALADUMO INTERNATIONAL HIGH SCHOOL WITHIN AND OUTSIDE THE SCHOOL ENVIRONMENT. THESE INCLUDE EXCURSIONS, SPORTING EVENTS / COMPETITIONS, RELIGIOUS EVENTS, CONFERENCES, AND OTHER EDUCATIONAL ACTIVITIES.
5. I SHALL ENDAEVOUR TO HONOUR INVITATIONS BY THE SCHOOL.
6. I SHALL COOPERATE WITH THE SCHOOL AUTHORITIES IN THE IMPLEMENTATION OF THE SCHOOL RULES AND REGULATIONS.
7. I CERTIFY THAT IN CASE OF EMERGENCY, WHEN I CANNOT BE CONTACTED AND A QUALIFIED MEDICAL DOCTOR ADVISES THE PRINCIPAL THAT AN URGENT OPERATION IS NECESSARY, I GIVE PERMISSION FOR SUCH OPERATION TO BE PERFORMED ON, AND ANAESTHETICS ADMINISTERED TO MY CHILD. I LEAVE THE EXTENT OF THE OPERATION TO THE DISCRETION OF THE SURGEON.
8. I SHALL PARTICIPATE ACTIVELY IN THE SCHOOL'S PTA (PARENT TEACHER ASSOCIATION).

(PARENT'S / GUARDIAN'S SIGNATURE)

DATE



STUDENT'S MEDICAL / HEALTH RECORD FORM 1

HEALTH ASSESSMENT TO BE COMPLETED BY PARENT(S) / GUARDIAN(S)

IN RESPECT OF YOUR CHILD'S ADMISSION TO ALADUMO INTERNATIONAL HIGH SCHOOL, YOU ARE REQUIRED TO SUBMIT A RECORD OF A PHYSICAL EXAMINATION BY A PHYSICIAN OR A CERTIFIED NURSE / MEDICAL PRACTITIONER COMPLETED NOT EARLIER THAN THREE (3) MONTHS BEFORE ENROLMENT, EXCEPT IN CASES OF CONTRAINDICATIONS. EVIDENCE OF IMMUNIZATION AGAINST COMMON CHILDHOOD DISEASES IS REQUIRED FOR ALL STUDENTS.

STUDENTS MAY ALSO BE EXEMPTED FROM IMMUNIZATION REQUIREMENTS IF A PHYSICIAN CERTIFIES THAT THERE ARE MEDICAL CONTRAINDICATIONS. IN ORDER TO ASSIST YOUR CHILD IN GAINING THE BEST FROM HIS/HER EDUCATOINAL EXPERIENCE, PLEASE COMPLETE PART 1 OF THIS HEALTH FORM. PART 2 MUST BE COMPLETED BY YOUR PHYSICIAN OR A MEDICAL PRACTITIONER.

THE FOLLOWING INFORMATION SHOULD BE COMPLETED WITH THE GREATEST INTEGRITY FOR THIS IS VITAL FOR THE WELLBEING OF YOUR CHILD WHILE ON BOARD.

(SURNAME OF STUDENT)	FIRST NAME
(OTHER NAME)	DATE OF BIRTH
(PHYSICIAN / MEDICAL PRACTITIONER'S NAME AND ADDRESS)	
OTHER SOURCE(S) FROM WHICH THE STUDENT RECEIVES HEALTH CARE. (IF NONE, WRITE 'NONE')	

	YES	NO	DETAILS (IF ANY)
INDICATIONS			
Allergies (Drugs, Food, Insects)			
Asthma			
Behaviour or Emotional Problem			
Birth Defects			
Bladder Problem			
Bleeding Problems			
Bowel Problems			
Cerebral palsy			
Concussion (Head Injury)			
Diabetes			
Ear Problem or Deafness			
Eye or Vision Problem			
Heart Problems			
Lead Poisoning			
Meningitis			
Prematurity			
Seizures			
Sickle Cell Disease			
Speech Problem			
Surgery			

If you would like to discuss your child's health with the School Health Personnel, please check title: YES NO

STUDENT'S MEDICAL / HEALTH RECORD FORM 2

HEALTH ASSESSMENT TO BE COMPLETED BY PHYSICIAN / MEDICAL PRACTITIONER

(SURNAME OF STUDENT)

(FIRST NAME)

(OTHER NAME)

(DATE OF BIRTH)

1. DOES THIS CHILD HAVE A HEALTH CONDITION(S) WHICH MAY REQUIRE EMERGENCY ACTION WHILE HE/SHE IS AT SCHOOL (E.G. SEIZURES, ASTHMA INSECT STIGN ALLERGY, BLEEDING PROBLEMS, HEART PROBLEMS)? IF 'YES', PLEASE DESCRIBE BELOW:

2. IS THIS CHILD ON LONG-TERM TECHNOLOGICAL ASSISTANCE? NO / YES _____

3. IS THERE ANY EVIDENCE FOR CONCERN IN THE AREAS LISTED BELOW? INDICATE THE RESULTS OF YOUR EXAMINATION IN THE UNDERLISTED AREAS

RESULTS

VISION _____

HEARING _____

SPEECH / LANGUAGE _____

DEVELOPMENT _____

ATTENTION DEFICIT / HYPERACTIVITY _____

4. IMMUNIZATION DPT / TD _____ POLIO _____ MMR _____ OTHERS _____

5. TUBERCULIN TEST RESULT NEGATIVE _____ POSITIVE _____

6. SHOULD THERE BE ANY RESTRICTION OF PHYSICAL ACTIVITY IN SCHOOL? IF YES, SPECIFY NATURE AND DURATION OF RESTRICTION? YES _____ NO _____ DESCRIBE: _____

7. PARTICIPATION IN SPORT ACTIVITIES: PLEASE CROSS OUT ANY ACTIVITY LISTED BELOW THAT THE STUDENT CANNOT PARTICIPATE IN: BASKETBALL / GYMNASTICS / SOFTBALL / TRACK / FIELD / CHEERLEADING / SKIPPING / VOLLEYBALL / CROSS-COUNTRY / KARATE / TACKWONDO / FOOTBALL / SWIMMING / TENNIS / OTHERS _____

IF YOU WOULD LIKE TO DISCUSS YOUR CHILD'S HEALTH WITH THE SCHOOL HEALTH PERSONNEL, PLEASE CHECK TITLE: YES NO

8. EYES: DATE OF EYE TEST: _____ RESULT: _____ (I.E. ARE EYEGASSES REQUIRED OR NOT?)

9. TEETH: DATE OF DENTAL VISIT: _____ (SHOULD BE WITHIN THREE MONTHS OF THE DATE ON THIS FORM)

10. TREATMENT OF MALARIA: ALLERGIC TO MEFLOQUINE / QUININE _____ YES NO

ALTERNATIVE MEDICINE USED: _____

11. IMMUNISATION: ALL STUDENTS MUST BE IMMUNISED AGAINST: (NOT INFANT IMMUNIZATION)

a. TETANUS: DATE OF IMMUNISATION: _____ DATE WHEN BOOSTER DOSE DUE: _____

b. YELLOW FEVER: DATE OF IMMUNISATION: _____ DATE WHEN BOOSTER DUE: _____

c. TYPHOID: DATE OF IMMUNISATION: _____ DATE WHEN BOOSTER DUE: _____

d. CEREBRO-SPINAL MENINGITIS: DATE OF IMMUNISATION: _____ DATE WHEN BOOSTER DUE: _____

e. HEPATITIS-B VACCINE: DATE OF IMMUNISATION: FIRST DOSE: _____

SECOND DOSE: _____

THIRD DOSE: _____

12. SKIN COMPLAINTS: PLEASE LIST ANY SKIN COMPLAINTS / ALLERGIES: _____

TREATMENT (IF APPLICABLE): _____

13. BLOOD: GENOTYPE: _____ BLOOD GROUP: _____

HBsAg: _____ G6PD: _____

14. SICKLE CELL ANAEMIA: _____ (YES / NO)

(IF YOUR WARD SUFFERS FROM SICKLE CELL ANAEMIA, PLEASE GIVE ALL NECESSARY DETAILS OF HISTORY AND TREATMENT ON A SEPARATE SHEET OF PAPER FOR THE BENEFIT OF THE HIGH SCHOOL NURSE AND ATTENDING DOCTOR.)

IT IS IMPORTANT FOR APRENTS / GUARDIANS OF ANY CHILD WITH CARDIO-VASCULAR AILMENTS, SICKLE CELL DISEASE AND EPILEPSY TO HAVE A SCHEDULED INTERVIEW WITH THE AUTHORITIES REGARDING ARRANGEMENTS FOR CONTINUED CARE OF SUCH PATIENTS.

15. CHEST X-RAY: PRESENT A RECENT X-RAY OF SKELETAL FRAMEWORK AP & LATERAL.

16. OTHERS:

a. ANAEMIA	YES / NO	g. HEAD INJURY	YES / NO
b. ARTHRITIS	YES / NO	h. KIDNEY PROBLEM / INJURY	YES / NO
c. BLADDER PROBLEM / INJURY	YES / NO	i. NOSE BLEEDS	YES / NO
d. CONVULSIONS / SEIZURES	YES / NO	j. TUBERCULOSIS	YES / NO
e. FAINTING SPELLS	YES / NO	k. ULCER	YES / NO
f. EAR PROBLEMS	YES / NO	l. WHOOPING COUGH	YES / NO

17. LIST ANY SURGICAL OPERATIONS AND DATES:

a. _____

b. _____

c. _____

d. _____

e. _____

18. HAS YOUR CHILD EVER HAD AN ILLNESS, CONDITION, OR INJURY THAT REQUIRED HIM / HER TO GO TO THE HOSPITAL EITHER AS AN OVERNIGHT PATIENT OR OPD OR FOR X-RAYS; REQUIRED AN OPERATION; CAUSED HIM / HER TO MISS CLASS? YES NO

19. IS YOUR CHILD UNDER MEDICAL CARE NOW? YES NO

FOR WHAT? _____

20. HAS YOUR CHILD TAKEN ANY MEDICATION IN THE PAST YEAR? YES NO

IF YES, WHY? _____

21. IS YOUR CHILD TAKING MEDICATIONS NOW? YES NO

IF YES, WHY? _____

22. HAS YOUR CHILD BEEN ILL FOR FIVE (5) CONSECUTIVE DAYS? YES NO

WHAT WAS THE NATURE OF AILMENT? _____

DO YOU HAVE ANY WORRIES ABOUT YOUR CHILD'S HEALTH OR OTHER QUESTIONS YOU WOULD LIKE TO DISCUSS WITH THE MEDICAL DIRECTOR? YES NO

NAME OF PARENT / GUARDIAN (PLEASE PRINT OR TYPE):

SIGNATURE OF PARENT / GUARDIAN: _____

ADDRESS: _____

PHONE CONTACT: _____ DATE: _____

NAME OF EXAMINER:

SIGNATURE OF EXAMINER: _____

ADDRESS: _____

PHONE CONTACT: _____ DATE OF EXAMINATION: _____