

# DARMAN MODEL COLLEGE

64, IJU ROAD,  
IFAKO-IJAIYE  
AGEGE, LAGOS.  
Tel: 07028213435  
01-7605035

1, HOLY CHILD WAY,  
SATELLITE TOWN,  
LAGOS.  
Tel: 08023167116,  
08033295810



www.darmanschools.org.

ACADEMIC SESSION

INTENDING CLASS

Affix  
Passport Size  
Photograph

## APPLICATION FOR ADMISSION

DMC 002375

This form is to be completed and returned, with 3 passport photographs of applicant, photocopies of birth certificate, testimonial from last school attended, transfer certificate where applicable and other relevant information to the Admission office of the College.

### SECTION A (PERSONAL DATA)

1. Surname: \_\_\_\_\_  
(Block Letters)
2. Other Name (s): \_\_\_\_\_
3. Height  Sex: Male  Female
4. Date of Birth: 

Day	Month:	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>
5. Nationality: \_\_\_\_\_
6. State of Origin: \_\_\_\_\_
7. Religion: \_\_\_\_\_
8. School Last Attended: \_\_\_\_\_
9. Class Completed: \_\_\_\_\_
10. Class into which Admission is being Sought: \_\_\_\_\_
11. Postal Address: \_\_\_\_\_  
Tel. No: \_\_\_\_\_ Email: \_\_\_\_\_
12. a. Name of Parent / Guardian: \_\_\_\_\_  
b. Occupation: \_\_\_\_\_  
c. Residential Address: \_\_\_\_\_ Tel No: \_\_\_\_\_  
d. Office Address: \_\_\_\_\_ Tel No: \_\_\_\_\_

13. a. Name of Local Guardian: \_\_\_\_\_  
 (If parent/guardian are not resident in Lagos)
- b. Relationship to Pupil: \_\_\_\_\_
- c. Contact Address: \_\_\_\_\_  
 \_\_\_\_\_ Tel No: \_\_\_\_\_

14. Have you any physical disability? YES OR NO   
 If yes, state the nature of the disability: \_\_\_\_\_

**SECTION B (ACADEMIC DATA)**

15. Certificate in view: \_\_\_\_\_
16. Indicate academic area of interest: Science  Art  Commercial
17. Vocational  Not known
18. Course of study you intend going for at the tertiary level: \_\_\_\_\_

**19. SCHOOLS ATTENDED**

	Nursery	Primary School	Junior Sec. Sch.	Senior Sec. Sch.	Break or Changes (if any)
Name of school					
Year of attendance					
Year left					
Reason for Leaving					
Certificate					

**20. Distinction and Prizes**

- (i) \_\_\_\_\_
- (ii) \_\_\_\_\_
- (iii) \_\_\_\_\_
- (iv) \_\_\_\_\_

21. Are you currently registered in another Secondary School? YES  NO

(If yes state the name of the Secondary School)

\_\_\_\_\_

\_\_\_\_\_

22. Name two persons to whom reference may be made (at least one of them should be your teacher at Nursery / Primary/Former school, as applicable)

(i) Name: \_\_\_\_\_ Occupations: \_\_\_\_\_

Designation: \_\_\_\_\_ Tel No \_\_\_\_\_

(ii) Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Designation: \_\_\_\_\_ Tel No \_\_\_\_\_

23. **SPONSORSHIP:** Give name and address of your sponsor (if any)

Name: \_\_\_\_\_ Address: \_\_\_\_\_

**SECTION C (FAMILY BACKGROUND)**

24.

Parents	Father	Mother	Guardian(s)
Name			
Contact Address			
Residential Address			
Telephone Number			
State of Origin			
Nationality			
Religion			
Occupation			
Deceased			

25. State type of family you belong to \_\_\_\_\_

How many children are you in the family? \_\_\_\_\_

What is your position in the family? \_\_\_\_\_

Are your parents living together? \_\_\_\_\_

Are your parents divorced? \_\_\_\_\_

**SECTION D (HEALTH RECORDS)**

30. **Physical Disabilities**

Tick as applicable Short sightedness  Squinting  Partial deafness

Long sightedness  Limping  Partial blindness  Stammering

And other (s) specify e.g *left handedness etc.* \_\_\_\_\_

31. Indicate whether you have ever suffered from any of the following through **Yes or No**

Measles  Chicken pox  Diphtheria  Whooping cough

Meningitis  Eye diseases  Ear diseases.

State any five other ones in case it is not mentioned.

(i) \_\_\_\_\_ (ii) \_\_\_\_\_ (iii) \_\_\_\_\_ (iv) \_\_\_\_\_

32. Family health history: Tick Yes or No whether any of your family members is suffering from the following:

Tuberculosis       Diabetes       Epilepsy       Asthma

Mental Disorder       Hypertension       Heart disorder       Cancer

33. Please indicate in the boxes provided below any of the vaccinations you have taken with dates:

(i)  Small pox Date \_\_\_\_\_ (ii)  BCG Date: \_\_\_\_\_

(iii)  Cholera Date: \_\_\_\_\_ (iv)  Polio vaccine Date: \_\_\_\_\_

(v)  Others: \_\_\_\_\_

34. **Undertaking by Parent/Guardian:**

If my child/ward should be ill, or injured while he/she is in school, I agree that he/she should receive medical treatment from the nearest approved medical centre at my own expenses.

Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

35. State precisely your preference for Darman Model College \_\_\_\_\_

36. **Declaration by applicant:**

I hereby declare that the information stated above is accurate in every detail, to the best of my knowledge.

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

**FOR OFFICIAL USE ONLY**

Date of purchase: \_\_\_\_\_

Receipt No of Application form fee: \_\_\_\_\_

Document Attached: (i) \_\_\_\_\_ (ii) \_\_\_\_\_ (iii) \_\_\_\_\_

(iv) \_\_\_\_\_ (v) \_\_\_\_\_ (vi) \_\_\_\_\_

Result of Applicant:  English       Mathematics       General Paper       Total

Date result communicated \_\_\_\_\_

Registration No (If Admitted) \_\_\_\_\_

Principal's comment and Recommendation \_\_\_\_\_

\_\_\_\_\_  
Signature: \_\_\_\_\_