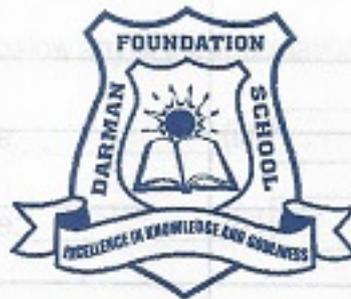


DARMAN FOUNDATION SCHOOL

(MONTESSORI)

64, IJU ROAD, IFAKO AGEGE-LAGOS. P.O.Box 15693 Ikeja. Tel: 01-8044476, 7749907



ACADEMIC SESSION

Affix
Passport Size
Photograph

INTENDING CLASS

APPLICATION FOR ADMISSION

DFS/00832

This form is to be completed and returned, with 3 passport photographs of the applicant, Photocopies of birth certificate and other relevant information are to be Submitted at the Admission office of the School.

SECTION A (PERSONAL DATA)

- Surname: _____
- Other Name (s): _____
- Date of Birth:

Day	Month	Year

 (b) Sex (c) Height
- Nationality: _____ State: _____
- Religion: _____
- School Last attended: _____
- Class completed: _____
- Class into which Admission is being sought: _____

SECTION B FAMILY BACKGROUND

9. Parents	Father	Mother	Guardian (s)
Name			
Contact Address			
Residential Address			
Office Address			
Telephone number(s)			
State of Origin			
Nationality			
Religion			
Occupation			

10. 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 C (HEALTH RECORDS)

11. 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. _____

12. 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 other ones in case it is not mentioned.

- (i) _____ (ii) _____ (iii) _____ (iv) _____

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

<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Mental Disorder	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Heart disorder	<input type="checkbox"/>	Cancer

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

(i)	<input type="checkbox"/>	Small pox	Date: _____	(ii)	<input type="checkbox"/>	BCG	Date: _____
(iii)	<input type="checkbox"/>	Cholera	Date: _____	(iv)	<input type="checkbox"/>	Polio Vaccine	Date: _____
(v)	<input type="checkbox"/>	Others:	_____				

15. What is your Blood group _____

16. What is your Genotypes _____

17. Food Allergy _____

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

A. 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.

B. I undertake and agree to pay each term's fees in advance I shall give a half term's written notice before withdrawing my child from the school or pay a term's fee in lieu of notice.

C. I also agree to comply with all conditions stipulated in your school prospectus which I have read carefully with full understanding.

Name: _____	Date: _____
Signature: _____	Address: _____

16. State precisely your preference for Darman Foundation School _____

17. **Declaration by applicant Parent / Guardian:**

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

_____	_____
Signature	Date

FOR OFFICIAL USE ONLY

Date of purchase: _____

Receipt No of Application form fee: _____

Document Attached: (i) _____ (ii) _____ (iii) _____

(iv) _____ (v) _____ (vi) _____

Result of Applicants class placement test: _____

Date result communicated _____

Registration No (If Admitted) _____

Head Teacher's comment and Recommendation _____

Signature: _____

18. Understanding by Parent / Guardian:

- A. 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.
- B. I undertake and agree to pay each term a fee in advance I shall give a full term's written notice before withdrawing my child from the school or pay a term's fee in lieu of notice.
- C. I also agree to comply with all conditions stated in your school prospectus which I have read carefully with full understanding.

19. State precisely your preference for Daman Foundation School

Name: _____ Date: _____

Signature: _____ Address: _____

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

16. Indicate which of the following diseases your child/ward has ever had or is likely to have:

Measles _____ Mumps _____

Scarlet fever _____ Whooping cough _____

Diphtheria _____ Tetanus _____

Polio _____ Typhoid _____

Cholera _____ Dysentery _____

Other _____

Signature: _____ Date: _____