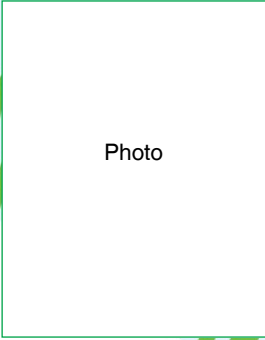




Student Application Form



*Requested Start Date

Year Month Day

*Class Level Applied For

- Nursery
(Born before August 31st, 2 years old prior to Sept 1st of each year)
- Preschool
(Born before August 31st, 3 years old prior to Sept 1st of each year)
- Lower Kindergarten
(Born before August 31st, 4 years old prior to Sept 1st of each year)
- Upper Kindergarten
(Born before August 31st, 5 years old prior to Sept 1st of each year)

*Campus Applied For

(Parents can remark preferred campus location but Springfield Kindergarten reserves the final decision on all student campus placement.)

- Central Park-View Springfield Kindergarten
- The Canton Mansion Springfield Kindergarten

Personal Details of Your Child

*Child's Chinese Name *Family Name *First Name

*Gender

Male Female

*Date of Birth

Year Month Day

*Nationality

*Passport Nationality

*ID or Passport Number

*Child's First Language

*Child's Additional Languages

*Position of Child

1st 2nd 3rd Others _____

*Does your child have any siblings?

No Yes, please list the number of Brother(s) / Sister(s): _____

Sibling Gender

Age

Sibling Gender

Age

Sibling Gender

Age

Sibling Gender

Age

Sibling Gender

Age

Sibling Gender

Age

Does your child have brothers and sisters in reading or have graduated from Springfield kindergarten?

No Yes

If yes, List the brothers / sisters and their names:

School History

Has never attended school before

Name and type of school last attended

From:

To:

Year

Month

Year

Month

Family Details

*Are you a resident of New World Central Park View, Canton Mansion or Canton First Estate?

No If Yes, please tenant owner

***Family Residential Address**

***Telephone No.**

Fax No.

Father's Information

***Name**

Nationality

ID or Passport Number

***Languages Spoken**

Occupation / Profession

Company Name

Office Telephone No.

***Mobile No.**

***Email Address**

Mother's Information

***Name**

Nationality

ID or Passport Number

***Languages Spoken**

Occupation / Profession

Company Name

Office Telephone No.

*Mobile No.

*Email Address

Student Medical Form

Allergies Is your child allergic to any medications, foods, animals, plants, insect bites or stings?

Allergy

Reaction

Has your child experienced or is experiencing the following illness(es)? If Yes, please ✓ the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Autism | <input type="checkbox"/> Bacillary Dysentery |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Cholera | <input type="checkbox"/> Clonic spasm | <input type="checkbox"/> Conjunctivitis |
| <input type="checkbox"/> Dengue Fever | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Febrile Seizure |
| <input type="checkbox"/> G6PD Deficiency | <input type="checkbox"/> Hand, Foot and Mouth Disease | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Influenza | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Meningococcal Infection | <input type="checkbox"/> Mumps | <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Pertussis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Rubella (German measles) | <input type="checkbox"/> SARS | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Viral Gastroenteritis |
| <input type="checkbox"/> Viral Hepatitis A | <input type="checkbox"/> Others (Please specify): | | |

How did you hear about us?

Content and Acceptance

I certify that the information provided above is true and correct.

*Applicant Name

*Relationship
