Student Application Form

Photo

***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:

- ☐ Anemia
- ☐ Asthma
- ☐ Autism
- ☐ Bacillary Dysentry
- ☐ Chickenpox
- ☐ Cholera
- ☐ Clonic spasm
- ☐ Conjunctivitis
- ☐ Dengue Fever
- ☐ Diphtheria
- ☐ Epilepsy
- ☐ Febrile Seizure
- ☐ G6PD Deficiency
- ☐ Hand, Foot and Mouth Disease
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ Influenza
- ☐ Measles
- ☐ Meningococcal Infection
- ☐ Mumps
- ☐ Poliomyelitis
- ☐ Pertussis
- ☐ Pneumonia
- ☐ Rubella (German measles)
- ☐ SARS
- ☐ Scarlet Fever
- ☐ Sleepwalking
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Viral Gastroenteritis
- ☐ Viral Hepatitis A
- ☐ 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**