STATEFIELDS SCHOOL, INC.

National Road, Molino III, Bacoor City, Cavite

APPLICATION FOR ADMISSION

AFC No.: _____

SY 20__ - 20__

☐ NEW ☐ RETURNING STUDENT ☐ FROM PHILIPPINE SCHOOL ☐ PRIVATE ☐ PUBLIC ☐ FROM FOREIGN SCHOOL BUT FILIPINO CITIZEN ☐ PHILIPPINE. SCHOOL ABROAD

Last Name

First Name

Middle Name

1x1 Colored Picture

Level Applying For **Academic Track**

Religion: (please check)
☐ CATHOLIC
☐ NON-CATHOLIC
Please Specify: _____

PERSONAL BACKGROUND

Date of Birth (mm/dd/yyyy) Place of Birth Age

Citizenship Tel No. Cellular No.

Sex: (please check)
☐ MALE
☐ FEMALE

Home/Mailing Address
House No. _____ Street _____ Village _____
Area/District _____ City/Prov. _____

EDUCATIONAL BACKGROUND

	Name of School (graduated from/last school attended)	Address	School Year
PRESCHOOL			
ELEMENTARY			
JUNIOR HIGH SCHOOL			
SENIOR HIGH SCHOOL			

FAMILY BACKGROUND

FATHER (as appeared in your child's birth certificate)

Last Name First Name Middle Name

MARITAL STATUS: ☐ MARRIED ☐ LEGALLY SEPARATED ☐ WIDOWER ☐ OTHERS _____

Occupation Citizenship Educational Attainment

Name of Company Office Address

Tel. No. Cellular No. E-mail

MOTHER (as appeared in your child's birth certificate)

Maiden Name First Name Middle Name

MARITAL STATUS: ☐ MARRIED ☐ LEGALLY SEPARATED ☐ WIDOW ☐ OTHERS

Occupation Citizenship Educational Attainment

Name of Company Office Address

Tel. No. Cellular No. E-mail

GUARDIAN (if not living with parents)

First Name _____ Middle Name _____ Last Name _____
House No. _____ Street _____ Village _____
Area/District _____ City/Prov. _____
Relation _____ Tel. No. _____ Cellular No. _____

STUDENT ID INFORMATION (In case of emergency, please notify:)

Please check one ☐ Father ☐ Mother ☐ Guardian

Brother / s and sister / s who have studied or who are presently enrolled at Statefields School, Inc, if there is any:

NAME	Grade / Level

HEALTH INFORMATION

HEALTH RECORD

Has your child had any of the following illnesses? Check those that have affected your child for the past 5 years up to the present.

CATEGORY A			CATEGORY B
☐ Cough & Colds	☐ Mumps	☐ Hyperactivity	☐ Allergy, severe (Food/Medicines)
☐ Dizziness	☐ Pneumonia	☐ Hepatitis	☐ Asthma, exacerbated attack
☐ Eye Defects	☐ Chicken pox	☐ Malaria	☐ Convulsion
☐ Headaches	☐ Stuttering	☐ Tuberculosis	☐ Diabetes
☐ Hearing Defects	☐ Typhoid Fever	☐ Hearing impairment	☐ Epilepsy / Seizure Episode
☐ Influenza	☐ Dyslexia	☐ Speech defect	☐ Fainting Spells
☐ Measles	☐ Hernia	☐ Others: please specify _____	☐ Heart Ailments

Was your child diagnosed with any congenital/inborn diseases? Yes / No _____

Please specify: _____

Was your child hospitalized because of an illness? _____

Date: _____ Diagnosis: _____

Has your child undergone minor/major surgery? _____ Date: _____

Please specify: _____

Was your child involved in any serious accidents? _____ Date: _____

Please specify or give Diagnosis: _____

PLEASE CHECK IF YOUR CHILD MAY BE GIVEN THE FOLLOWING MEDICINES/OINTMENTS

___ Aceite Mansanilla	___ Betadine oral solution	___ Flammazine ointment	___ Ventolin Nebulization
___ Alaxan 500mg tablet	___ Betadine antiseptic soln.	___ Kremil-S	___ Visine/Eye mo
___ Ambroxol tablet	___ Celestamine tablet	___ Mefenamic acid 250mg (for pain)	___ Paracetamol tablet 500mg
___ Bioflu tablet	___ Claritin syrup	___ Mefenamic acid 500mg (for pain)	___ Petroleum jelly
___ Bonamine tablet	___ Decolgen ND/Neozep	___ Omega liniment	___ Vicks vaporub
___ Buscopan tablet	___ Diatabs/Imodium	___ Relestal syrup (for abd. Pain)	___ White flower
___ Bactroban Cream	___ Efficascent oil	___ Tempra forte syrup	

REMARKS FROM THE PARENTS/GUARDIANS:

(other diseases / allergies / diagnosis not being mentioned or any special needs / care or other concerns for your child).

Please disclose correct and complete information.

_____

_____

IMMUNIZATION HISTORY

Complete immunization is vital for disease prevention. Without it, would make your child susceptible to diseases.

Please check (√) the kind of vaccines given to your child for proper advice.

		YES	NO
➢ BCG		☐	☐
➢ DPT	*1*	☐	☐
	2	☐	☐
	3	☐	☐
➢ POLIO	*1*	☐	☐
	2	☐	☐
	3	☐	☐

		YES	NO
➢ INFLUENZA		☐	☐
➢ PNEUMONIA		☐	☐
➢ HEPATITIS	*1*	☐	☐
	2	☐	☐
	3	☐	☐

	YES	NO
➢ MEASLES	☐	☐
➢ MMR	☐	☐
➢ DENGVAXIA	☐	☐

OTHERS: Please specify _____

All information contained herein is true, correct and complete to the best of my knowledge. Parents/Guardians hereby hold the school and/or school physician free and harmless from any liability or responsibility arising from any false or misrepresentation of data or any adverse effect or reaction to drugs instituted or prescribed to students on the basis of information given or supposed to have provided by the said parents or guardians. Any false statement or misrepresentation made above may be a ground for the non-admission or exclusion of our son/daughter/ward.

_____ _____ _____

Parents / Guardian's Name & Signature *Relationship* *Date*