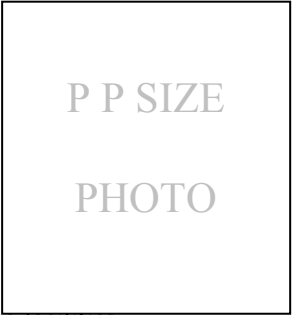


ST. JOHN'S SCHOOL WHITEHALL
STUDENT ENROLMENT FORM
(0364-2537491)



APPLICATION FOR ADMISSION

I wish to apply for a place in the School for class _____ in the year 200 ____ with/without boarding facilities.

STUDENT'S SURNAME: _____

OTHER NAMES: _____

DATE OF BIRTH: ____ / ____ / ____ AGE AS ON 1 MARCH 200 ____ / ____ PLACE OF BIRTH: _____
 dd mm yyyy

PRESENT SCHOOL _____ CITY _____

READING IN CLASS _____ WHETHER PROMOTION GRANTED YES /NO _____

REASONS IF NO _____ CONNECTIONS, with the school (e.g. brother / sister enrolled or past pupil etc) if any _____

FATHER'S NAME: _____ OCCUPATION _____

HOME ADDRESS: _____

CITY _____ STATE _____ PIN CODE _____

WORK PHONE _____ HOME PHONE _____ MOBILE PHONE _____

E-MAIL ADDRESS _____

MOTHER'S NAME: _____ OCCUPATION _____

WORK PHONE _____ MOBILE PHONE _____ E-MAIL ADDRESS _____

Special family/marital circumstances if any (e.g. separated, deceased) _____

This form of Application is understood to be an undertaking, on the part of Parents, or Guardians that the boy / girl will conform to the Rules and customs of the School, if enrolled. After admission to the School, enrollment of subsequent years is always subjected to satisfactory conduct, progress and application, as well as acceptance of the Class and Grading determined by the Headmaster, and due payment of fees.

SIGNATURE OF FATHER _____ DATE _____ MOTHER _____ DATE _____

CHECK LIST (For office use only)			
Enrolment Officer		Management Officer	
Interviewed	Yes/No	Transfer Certificate submitted	Yes/No
Entrance Test	Yes/No	Birth Certificate submitted	Yes/No
Entrance Test Result	Pass/Failed	Registration fee	Rs. _____
Date ____/____/____	Signature _____	Date ____/____/____	Signature _____

Please include an enrolment fee of Rs.150 and two coloured passport size photographs of student and one family photograph with this application.

ST. JOHN'S SCHOOL WHITEHALL
SHILLONG 793014
(0364-2537491)

MEDICAL CERTIFICATE

To be completed by the Family Medical Advisor

NAME OF STUDENT _____

DATE OF BIRTH _____ Height _____ Weight _____

Please give details of the following:

Immunisations

Date	Date	Date
Whooping Cough _____	Diphtheria _____	Tetanus _____

Polio _____	Measles _____	Mumps _____
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Chicken Pox _____	Typhoid _____	Rubella (G/Measles) _____
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Cholera _____	Hepatitis B _____	BCG (TB) _____
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Illnesses and Operations

Date	Date	Date
Whooping Cough _____	Asthma _____	Measles _____

Fits _____	Mumps _____	Enuresis _____
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Chicken Pox _____	Drug Allergies _____	Tonsillectomy _____
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Appendectomy _____	TB _____	Others _____
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Any dental problems _____

Any skin infection _____

Other significant medical conditions: (It is vital that his information is filled in accurately. Any omissions could adversely affect the child in the event of an illness) If a child is wearing spectacles, a second pair must be deposited with the school authority.

I consider the above named-person to be in sound health and free from any defect disabling him or her from school life.

Signature of Medical Advisor _____ Date _____

Address _____

This form must be filled in and returned to the school office as soon as possible