

Admission Checklist for New Students Quality Schools International, Dili

	Student's Family Name	First Name
	Student's Family Name	THSt Ivallic
Z.	Student Application	n
	School and Family	Information,
	Health History	
e de	Emergency Informa	tion
THE STATE OF THE S	Transcripts or Previo	ous Report Cards

Welcome to the home of the Dili Crocs!



Student Application

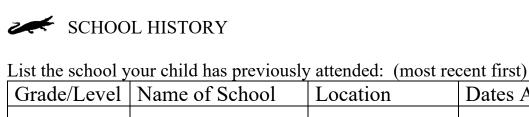
	Expected Date of Entry:
(Please Print) Family Name:	
Given Names:	
Date of Birth:/	_ Sex:
Day Month Year	
Citizenship:	
Parents or Guardians:	
Father's Name:	Company:
Father's Occupation:	Mobile:
Father's Work Phone:	Email:
Mother's Name:	Company:
Mother's Occupation:	Mobile:
Mother's Work Phone:	Email:
Local Address:	
May we place your telephone numbers in o	ur school directory that is distributed only to
QSID parents? Yes No	
Responsibility for fees: Personal Con	npany/Organization



A non-refundable registration fee of \$300 is required for each new student and should accompany the completed registration form.



School and Family Information



List the school your child has previously attended. (most recent hist)			
Grade/Level	Name of School	Location	Dates Attended

Has your child been in any special programs?	Yes	No	If yes, please
give details.			

Sibling Information

Name	Sex	Date of Birth day/month/year

Additional Family Information that would be helpful for us to know:

Language Information

Primary (first) Language	
Language spoken at home	
Second Language	
Other:	



Health History



Please submit a copy of your child's immunization records <u>or</u> the <u>dates</u> of their last immunizations below.

Diphtheria	BCG
Pertussis	Meningitis
Tetanus	Typhoid Fever
Polio	Rabies
Measles	Influenza
Mumps	Hepatitis A
Rubella	Hepatitis B
Yellow Fever	Other

DEVELOPMENTAL HISTORY

Were there any complications in the	he pre-natal, del	ivery, or post-natal periods?
Yes No If yes, please		
When did your child walk?	months old	
Your child's first word?		months old
Your child was toilet trained at wh		
MEDICAL HISTORY		
Does your child have a health con-	dition that the so	chool should be aware of?
Yes No If yes, please		
Does your child take medication for	or this condition	, or for any other reason?
Yes No If yes, please	e explain:	<u>-</u>
Will you be sending this medication		use when needed?
Yes No If yes, please attach instructions and place medication in a		
sealed bag with your child's name		-
Z ,	Č	•
Please list the date of occurrence of	or check ailment	s that are appropriate.
Broken Bones	Allergies	
Surgery Hay fever		
Hearing loss	Other	
Vision	Other	



Emergency Instructions

In the event that your child is injured or for any reason needs emergency medication attention, the following information is required:

Emergency Contact: QSID will only contact this person if we are unable to contact the parents. This person should know your family and should be able to act on your behalf until you can be contacted.

Name:	_ Mobile:
Relationship:	Alternative #:
Secondary contact:	
Name:	_ Mobile:
Relationship:	_ Alternative #:
If emergency medical care is required, do medical care, possibly in include locating child to a medical facility?	•
Yes No	
If yes, medical facility preference:	
Phone Number of facility:	
Preferred Doctor:	
Phone Number of Doctor:	
In an emergency, I authorize QSID to take medical treatment to my child/ren in the econtacted at the time.	e any steps necessary to administer
Signature:	Date:

