SHEIKH ZAYED INTERNATIONAL ACADEMY - ISLAMABAD

أكاديمية الشيخ زايد الدولية - إسلام أباد

STUDENT REGISTRATION FORM

STUDENT NAME

FIRST	**MIDDLE**	**LAST**

DATE OF BIRTH

MONTH	**DAY**	**YEAR**

PLACE OF BIRTH

NATIONALITY

LANGUAGE SPOKEN

PASSPORT NUMBER

COMPLETE ADDRESS DETAILS

In Pakistan

Please Attach 6 Photographs + Photocopy of Passport/Birth Certificate + School Leaving Certificate + the Report Cards and Behaviour Reports of the two Previous years.

GENDER MALE FEMALE

Name of the Last School Attended:	
Last Grade Level:	
Number of Years Attended:	
School's Mailing Address:	
Contact Numbers (including international code):	
School's Website / e-mail:	

Father's name:	**Mother's Name:**
Occupation:	**Occupation:**
Name of Company:	**Name of Company:**
Mobile #:	**Mobile #:**
Work Telephone #:	**Residence Telephone #:**
E-Mail:	**E-Mail:**

Person to be contacted in case of an emergency:

NAME: _____

RELATION TO THE STUDENT _____

CONTACT DETAILS _____

For Office Use Only

ACCEPTED ☐ NOT ACCEPTED ☐

GRADE LEVEL _____

RESERVATIONS _____

REMARKS _____

_____

_____

_____ _____

PRINCIPAL'S SIGNATURE DATE

IB WORLD SCHOOL

UNIVERSITY OF CAMBRIDGE

STUDENT HEALTH FORM

Part I : To be filled by Parents or Guardians Only

STUDENT NAME:

_____ _____ _____

FIRST **MIDDLE** **LAST**

DATE OF BIRTH:

_____ _____ _____

MONTH **DAY** **YEAR**

GENDER **M** ☐ ☐ **F**

COMPLETE ADDRESS DETAILS:

NAME OF MOTHER_____ **MOBILE NUMBER** _____ **WORKPLACE NUMBER** _____

NAME OF FATHER _____ **MOBILE NUMBER** _____ **WORKPLACE NUMBER** _____

Name of the Person, other than Parents who could be contacted in emergency

NAME _____ **RELATION** _____ **PHONE NUMBER** _____

NAME _____ **RELATION** _____ **PHONE NUMBER** _____

In case of Emergency, Name & Telephone number of your Clinic /Local Physician whom you would like us to contact

Physician Number _____ **Contact Number** _____

In case of emergency may we take your Child to Shifa International Hospital –Islamabad? ☐ **YES** ☐ **NO**

Dose the Child have any?

☐ **Allergies**

☐ **Unusual Health Problems or Special Needs (e.g. Diabetes, Asthma, ADHD)**

☐ **Dietary Restrictions**

☐ **Regular Medication Given**

Name _____ **Dose** _____ **Time Give** _____

If you've checked any of the above please explain

If you wish to give permission for the nurse to give the basic medication to your child at School, Please Check

☐ **Paracetamol (Tylenol)** ☐ **Antacid** ☐ **Decongestant**

☐ **Ibuprofen** ☐ **Throat lozenges**

☐ **Any other medication that Doctor may decide**

STUDENT HEALTH FORM

Part II: To be filled by a Child Specialist or Child's Regular Physician

Student's Name _____ _____ _____ M ☐ F ☐

First Middle Last

Student's Date of Birth _____

Name of Father: _____

Vision Screening Right Eye 20/ ____ Left Eye 20/ _____ Both 20/ _____

Hearing Screening Right Ear _____ Left Ear _____ Equipment Used _____

Weight
BP
Height
Blood Hb / Blood Group
URINE Albumin

General Physical Examination: _____

General appearance: _____

Nutritional Status: _____

Posture / Motor Behaviour: _____

Ear Nose Throat: _____

Heart: _____

Lungs: _____

Abdomen: _____

Genitalia (Tanner Stage): _____

Bones, Joints, Muscles _____

Neurological: _____

Skin: _____

Other: _____

Estimated Developmental Level: _____

Summary of abnormal findings, if any:

_____

_____

Medical Diagnoses: _____

Assessment: _____

Recommendations and referrals made, if any:

_____

_____

Physician Name: _____ Physician Number: _____

Physician Address: _____

Physician Signature: _____ Date: _____

STUDENT HEALTH FORM

Part III: Immunization Record

STUDENT HEALTH FORM

IMMUNIZATION RECORD

DATES OF SERIES AND BOOSTERS	PRIMARY SERIES				BOOSTERS		
VACCINE TYPE	1ST DOSE M/D/Y	2ND DOSE M/D/Y	3RD DOSE M/D/Y	4TH DOSE M/D/Y	NO:1 M/D/Y	NO:2 M/D/Y	COUNTRY IN WHICH THE IMMUNIZATION WAS GIVEN
DPT							
DIPHTHERIA							
PERTUSSIS							
TETANUS							
POLIO (OPV/IPV)							
MMR							
MEASLES OR MMR							
MUMPS OR MMR							
RUBELLA OR MMR							
BCG/TYNE TEST							
HEPATITIS B				x			
HEPATITIS A				x			
RABIES							
TYPHOID							
MENINGITIS							

HEALTH SCREENING				
YEAR	HEIGHT	WEIGHT	VISION	HEARING

REQUIRED IMMUNIZATIONS OR REQUIRED NUMBER OF DOSES		
DOSE		OPV/IPV 4 Primary doses
BIRTH	OPV/IPV	Booster No 1 at 4-5 years
6WK	DPT&OPV/IPV	Booster No 2 at 11-12 years
10WK	DPT & OPV/IPV	DPT 3 Primary doses
14WK	DPT & OPV/IPV	Booster No 1 at 4-5 years
9 MO	MEASLES	Booster No. 2 at 11-12 years
15 MO	MMR	
4-6 YRS	DPT & OPV	MMR 1 Primary dose at 1 year
11-12 YRS	MMR	Booster at 11-12 years

Physician Name: _____ Physician Signature: _____

Physician Address: _____ Date: _____

HOW WELL DO YOU KNOW YOUR CHILD!

To be filled by Parents

Dear Parents,
The following information about your child would enable us to reach to them better, motivate them, put them in the right places and encourage the growth of their skills.

1. **List qualities that you feel are points of strengths in your child (+ve) and qualities that you feel need encouragement and improvement (△)**

+ve	△

2. **Hobbies and Extra Curricular Activities of interest:**

3. **Likes and Dislikes:**

4. **A General overview that you feel is important for us to know: Your child, Character wise**
