



**Your Local International School**

**ABOUT THE STUDENT**

Family Name \_\_\_\_\_

First Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Day Month \_\_\_\_\_ Year \_\_\_\_\_

Citizenship: \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile \_\_\_\_\_

Fax Number \_\_\_\_\_ E-mail \_\_\_\_\_



Please send this form to:  
The Admissions Department  
MGIS - Manila  
Telefax (+632) 776-11-65 to 67  
Email: [secretariat@mgis.com.ph](mailto:secretariat@mgis.com.ph)  
Website: [www.mgis.com.ph](http://www.mgis.com.ph)

**APPLICATION FORM**

**EDUCATIONAL HISTORY**

Name of School & Country	Type of School (Preschool - Elem)	Attended		Grade Level (s)	International School
		From Mo/ Yr	To Mo/ Yr		YES / NO

**ABOUT THE PARENT OR LEGAL GUARDIAN**

Family Name \_\_\_\_\_ First Name \_\_\_\_\_

Profession \_\_\_\_\_ E-mail \_\_\_\_\_

Mailing Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile \_\_\_\_\_

# STUDENT HEALTH FORM

Name: \_\_\_\_\_

Date of Birth : Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Height (cm) \_\_\_\_\_

Sex:  Male  Female Weight (kg) \_\_\_\_\_

Blood Type / Rhesus Factor \_\_\_\_\_

Father's Telephone / Mobile Phone \_\_\_\_\_

Mother's Telephone / Mobile Phone \_\_\_\_\_

1. Has your child undergone medical treatment during the past 6 months?

- No  
 Yes. Reason for medical treatment \_\_\_\_\_

2. Vaccinations

Please furnish a photocopy of the immunization records

## PERSONAL HISTORY

Have you ever had or do suffer from:

	No	Yes (If yes, when)		No	Yes (If yes, when)
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/> _____	Asthma	<input type="checkbox"/>	<input type="checkbox"/> _____
Skin Problems	<input type="checkbox"/>	<input type="checkbox"/> _____	Hepatitis A/B/C	<input type="checkbox"/>	<input type="checkbox"/> _____
Measles	<input type="checkbox"/>	<input type="checkbox"/> _____	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/> _____
Mumps	<input type="checkbox"/>	<input type="checkbox"/> _____	Epilepsy's	<input type="checkbox"/>	<input type="checkbox"/> _____
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/> _____	Primary Complex	<input type="checkbox"/>	<input type="checkbox"/> _____
ADD / ADHD	<input type="checkbox"/>	<input type="checkbox"/> _____	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/> _____

For the following points, please specify if you: \_\_\_\_\_

Have any other disease or have had an operation recently \_\_\_\_\_

Have dyslexia or other learning problems (indicate to what degree) \_\_\_\_\_

Have allergies to any medicine or other products \_\_\_\_\_

Take any medication on a regular basis \_\_\_\_\_

Are on special diet \_\_\_\_\_

Have had any accident with long term consequences \_\_\_\_\_

with regards to any of the above special needs or medical condition you may have, MGIS aims to create an environment which enables all students to participate fully in campus life. To help us make reasonable adjustments, it is necessary to clearly indicate your special needs (i.e. Dyslexia) or medical condition. Please note that consideration of how we can meet any special needs is separate to the assessment of your academic suitability

How would you describe your general health condition?

- Excellent  Very good  Good  Poor

In keeping with school policies regarding preventive health measures, the School Director may request a student to undergo a medical checkup at any time his/her at MGIS.

I hereby certify that the above information is correct and that I agree to undergo a medical check up if required. Deliberate false statements may result in expulsion. MGIS will not be held responsible in case of incorrect medical information stipulated on the Medical Certificate and a Physician's Report

Signature of the student \_\_\_\_\_ Date \_\_\_\_\_

Signature of the parent or legal guardian \_\_\_\_\_ Date \_\_\_\_\_

## CLINICAL EVALUATION

Please indicate if the patient has experienced any problems with the following:

	Yes	No	Details
1. Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Head, Neck & Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Eyes & Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Mouth & Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Chest, Breast & Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Heart & Blood Vessels	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Digestive System	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Skeletal, Muscular System	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Urinary, Reproductive System	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Others (specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other comments	_____		

## AUTHORIZATION

### DURING EMERGENCY

I hereby give permission for emergency measures to be initiated in case of accident or sudden illness with the understanding that I will be notified immediately. I give permission to the school to bring my child to COMMCARE Clinic at Merville Park Subdivision.

Yes

No

## MEDICATION

With your permission, the school nurse can give the following medication without contacting you first.

For all ages

Paracetamol (headache or minor discomfort)

Lozenges-Strepsils, Dequadin (for mild sore throat)

Ointment

Lotions-Caladril (itchiness)

For middle school

Ibuprofen (for menstrual cramps and body pains)

Loperamide (for diarrhea)

Antacids (for "gas" and "acid stomach")

Yes

No

### FOR CONTINUOUS MEDICATION

If your child will be taking medication daily at school (such as antibiotics, ritalin) or may require tam for emergency (inhalers, Epipen, etc.) you must provide the school nurse with the medication and its original container, a prescription / letter from the doctor and this completed form.

This must be completed if your child needs to take no-prescription medicine from home. The PARENT or other adult must bring such medication to the school nurse

\_\_\_\_\_  
Parent Name & Signature

\_\_\_\_\_  
Guardian Name & Signature

\_\_\_\_\_  
Date of Application

## HOW DID YOU FIRST HEAR ABOUT US?

- Internet / Website
- Referral (indicate the name) \_\_\_\_\_
- Walked - In
- Student
- Industry Professional
- Advertising / Article in a newspaper

## MOTHER TONGUE AND ENGLISH LEVEL

If ENGLISH is not your mother tongue or if you have not spent at least 3 years in an ENGLISH speaking school, please estimate you child's ENGLISH ability.

SKILL AREA	VERY GOOD	GOOD	FAIR	LIMITED
LISTENING				
SPEAKING				
READING				
WRITING				

## STATEMENT

I hereby declare that all information given on this form is exact and complete. I acknowledge having read and understood this document and all other pertaining documents and will abide by the Standards of MGIS.

\_\_\_\_\_  
Signature of Father/Guardian

\_\_\_\_\_  
Signature of Mother/Guardian

Date: \_\_\_\_\_

Date: \_\_\_\_\_

## EMERGENCY CONTACT

Name: \_\_\_\_\_

Telephone No. \_\_\_\_\_

Relationship: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Address: \_\_\_\_\_

E-mai Address: \_\_\_\_\_

## VERY IMPORTANT

Please return this form fully completed and make sure the following are enclosed:

- \* Completed application form
- \* Photocopy of student's birth certificate
- \* Photocopy of previous school records
- \* Photocopy of any special needs report (if any)
- \* 2 passport size photographs
- \* 1 photocopy of your valid passport or Visa-ACR showing your name and nationality
- \* Students medical background/history, and physical examination report