

APPLICATION FORM

Name : _____
Surname First name Middle name Nick name

Date of birth: _____ Place of birth _____

Address _____

Tel. _____ Nationality _____ Religion _____

E-Mail: _____ Line ID/We-Chat: _____

For non-Thai nationals

Copy of child's passport received including visa page ☐ (tick)

Copy of parent's passport received including visa page ☐ (tick)

For Thai nationals

Birth certificate copy received ☐ (tick)

Copy of parent's ID card received ☐ (tick)

Language: A. What is the child's home (or first) language?

☐ Thai

☐ English

☐ Other (please specify) _____

B. Is she/he bilingual? ☐ Yes ☐ No

What are the other languages he/she can speak?

(Please specify) _____

Previous schools attended:

Age	Name of school	Location	Type of school Thai//International	Period		Year or Grade Level
				From	To	

PARENT'S DETAILS**FATHER:**_____
Surname/Family Name_____
First name_____
Middle name_____
Nick name

Nationality _____ Passport No. _____ Type of Visa _____

Organization/Company _____ Position _____

Office address _____

Tel. (Office) _____ Mobile: _____ Fax. _____

Email _____ Line ID/We Chat ID _____

MOTHER:_____
Surname/Family Name_____
First name_____
Middle name_____
Nick name

Nationality _____ Passport No. _____ Type of Visa _____

Organization/Company _____ Position _____

Office address _____

Tel. (Office) _____ Mobile: _____ Fax. _____

Email _____ Line ID/We Chat ID _____

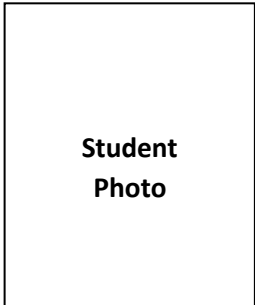
EMERGENCY CONTACTS

Usually in an emergency we will call the parents at the number given above. If we cannot contact either parent, we ask for you to give us a third number whom we can contact in case of an emergency.

Name: _____ Relationship: _____

Address _____

Tel. (home) _____ (Mobile) _____ (Office) _____



Child's name: _____ Grade: _____

Surname *First Name* *Nick Name*

Date of Birth: _____ (dd) _____ (mm) _____ (yyyy) **Age** _____

Emergency Contact: _____ **Telephone:** _____

Emergency Contact: _____ **Telephone:** _____

Student Conditions/ Illness (mark with x)									
Asthma	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Allergy	<input type="checkbox"/>
Anaphylaxis	<input type="checkbox"/>	G6PD	<input type="checkbox"/>	Dermatitis	<input type="checkbox"/>	Visual impairment	<input type="checkbox"/>	Hearing Impairment	<input type="checkbox"/>
Speech and Language Disorder/Delay	<input type="checkbox"/>	Physical Disability	<input type="checkbox"/>	Sensory Integration Issues	<input type="checkbox"/>	ADHD	<input type="checkbox"/>	Autism/ Asperger's	<input type="checkbox"/>
Developmental Delay	<input type="checkbox"/>	Travel Sickness	<input type="checkbox"/>	Other	<input type="checkbox"/>	Other	<input type="checkbox"/>	Other	<input type="checkbox"/>
DETAILS: (Please give as much information as possible.)									

-If yes please give details in the box below:

Name of Medication	Reason for Medication	Dosage	Frequency

Parent/Guardian Signature: _____ **Date:** _____

(Print Name): _____

