JVB LEADERSHIP ACADEMY

An Early Childhood Commission Institute
&
PREPARATORY SCHOOL

Student Application

Personal Information

ENTRY #_____ CERTIFICATE #_____

CHILD'S NAME: _____

DATE OF BIRTH: ____/___/____ AGE: _____YRS_____ MONTHS_____SEX: M ☐ F ☐

MOTHER'S NAME _____

MOTHER'S OCCUPATION_____ TELEPHONE_____

ADDRESS_____

FATHER'S NAME _____

FATHER'S OCCUPATION _____ TELEPHONE_____

ADDRESS: _____

RELIGION AFFILIATION _____

LAST SCHOOL ATTENDED_____

REASON FOR
LEAVING_____

CLASS PLACE ON ADMISSION_____ CLASS ON LEAVING_____

NO. OF SIBLING(S)_____ PLACE IN FAMILY_____ PET NAME _____

DESIRED GRADE OF ENTRY _____

EMERGENCY CONTACT INFORMATION (OTHER THAN PARENT/GUARDIAN)

NAME _____ RELATION _____

ADDRESS: _____

TELEPHONE NO: _____

FAMILY DOCTOR OR HEALTH CLINIC: _____

ADDRESS: _____

TELEPHONE NO: _____

STATE DIETARY REQUIREMENT (IF ANY) _____

Medical History

Please respond by putting a tick ( ) under the appropriate column and record dates of last treatment and remarks for positive responses.

Has your child ever been diagnosed or treated for any of the following conditions?

Past History	Yes	No	Date(S)	Remarks
❖ Asthma	( )	( )	_____	
❖ Bronchitis	( )	( )	_____	
❖ Tuberculosis (TB)	( )	( )	_____	
❖ Disorders of the Ears/Nose/Throat	( )	( )	_____	
❖ Rheumatic Fever/RH. Heart Disease	( )	( )	_____	
❖ Heart Disease	( )	( )	_____	
❖ Epilepsy (Fits)	( )	( )	_____	
❖ Mental Disorders	( )	( )	_____	
❖ Learning Disability	( )	( )	_____	
❖ Physical Disability	( )	( )	_____	
❖ Disorders Of The Kidney/Bladder	( )	( )	_____	
❖ Disorders Of Stomach/Bowels	( )	( )	_____	
❖ Sickle Cell Trait/Disease	( )	( )	_____	
❖ High Blood Pressure	( )	( )	_____	
❖ Diabetes Mellitus (Sugar)	( )	( )	_____	
❖ Leukemia/Lymphoma	( )	( )	_____	
❖ Typhoid	( )	( )	_____	
❖ Headaches	( )	( )	_____	
❖ Anemia (Week Blood)	( )	( )	_____	
❖ Fainting Spells/Giddiness	( )	( )	_____	
❖ Excess Tiredness	( )	( )	_____	
❖ Visual Disorders	( )	( )	_____	
❖ Hepatitis B	( )	( )	_____	
❖ Meningitis	( )	( )	_____	
❖ Allergies to Medication	( )	( )	_____	

- ❖ List Other Condition ( ) ( )_____

Has your child ever been admitted to hospital or had surgery? Yes ☐ No ☐

If yes, please explain for what reason._____

_____

Regular medications taken (if any): _____

Family History

Has any family member been diagnosed with the following?

	Yes	No	Date(S)	Remarks
❖ Asthma	( )	( )	_____	
❖ Allergies	( )	( )	_____	
❖ Diabetes Mellitus	( )	( )	_____	
❖ Tuberculosis	( )	( )	_____	
❖ Cancer/Tumors	( )	( )	_____	
❖ Sickle Cell Disease	( )	( )	_____	
❖ Mental Disorder	( )	( )	_____	
❖ Heart Disease	( )	( )	_____	
❖ Migraine	( )	( )	_____	
❖ High Blood Pressure	( )	( )	_____	

I certify that the above information is correct.

Signature: _____ Date: _____
(Parent/Guardian)

This application must be accompanied by the following documents. Applications will not be accepted without these items

- Current Immunization Record for the child.
- Passport sized photograph of child.
- Copy of Birth Certificate
- Medical Exam report.
- Registration Fee
- Letter of recommendation

Received by _____ Date _____

Accepted _____ Declined _____

Reason: _____

_____