



BANGALORE INTERNATIONAL SCHOOL

Geddalahalli, Hennur Bagalur Road, Kothanur Post, Bangalore - 560 077 INDIA

Tel: 28465060, 28445599, 28445852, Fax : 28465059 email : bis_blr@vsnl.net www.bangaloreinternationalschool.com

APPLICATION FORM

APPLN.No.		GRADE APPLIED FOR		DATE	
NAME OF STUDENT (FIRST)		(MIDDLE)		(LAST)	
STUDENT'S BIRTH DETAILS	DATE OF BIRTH (DAY)		(MONTH)	(YEAR)	
	PLACE OF BIRTH (CITY)			COUNTRY OF BIRTH	
	NATIONALITY				
FATHER'S DETAILS	NAME OF FATHER (FIRST)		(MIDDLE)	(LAST)	
	PROFESSION		OCCUPATION		NATIONALITY
MOTHER'S DETAILS	NAME OF MOTHER (FIRST)		(MIDDLE)	(LAST)	
	PROFESSION		OCCUPATION		NATIONALITY
ADDRESSES	HOME ADDRESS				PHONE #1
					PHONE #2
	E-MAIL				
	CITY	PIN / ZIP CODE		COUNTRY	MOBILE
	OFFICE ADDRESS				PHONE
	E-MAIL				
BROTHERS AND SISTERS	NAME OF BROTHER/SISTER IN SAME SCHOOL		DATE OF BIRTH		GRADE STUDYING IN
	1.				
2.					
STAY	FOR NRI ONLY : YEAR OF STAY ABROAD			FOR FOREIGNERS ONLY : EXPECTED LENGTH OF STAY IN BANGALORE	
PREVIOUS ACADEMIC RECORD	NAME OF SCHOOL		PLACE	GRADE (WHILE LEAVING)	NO. OF YEARS

AFFIX RECENT
PASSPORT SIZE
PHOTO HERE

ANY OTHER INFORMATION TO SUPPORT THIS APPLICATION

ENCLOSURE: FEE STRUCTURE

PARENT / GUARDIAN'S SIGNATURE

DATE

Principal Sign

Date

Please attach: CHECK LIST

1. Passport size Photograph
2. Copy of Birth Certificate
3. School Leaving Certificate
4. School Performance Report
5. Copy of Passport (foreign Nationals)



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HEALTH HISTORY FORM

Name of Student Grade

Emergency Phone Number (To reach Parents)

Physician to be called in an emergency (Name)

Address (Phone)

Neighbour / Friend / relative to be called in an emergency (Name)

Address

Phone

Has your child ever had any of the following illness ? If so when ?

Name	Yes/No	Date	Name	Yes/No	Date
Chickenpox			Epilepsy		
Measles			Tuberculosis		
German Measles			Whooping Cough		
Mumps			Ear Condition		
Diphtheria			Operation (Name)		
Rheumatic fever			Asthma		
Heart Disease			Allergies		
Poliomyelitis			Serious injury (Name)		
Diabetes Mellitus			Others		
Blood Group					

Has your child had any of the following protective measures ? If so, when ?

Name	Yes/No	Date	Name	Yes/No	Date
BCG Vaccination			Tetanus		
Polio			Hepatitis A & B		
MMR			Others		

Date of last physical check up.....

If there is anything concerning the health of your child, which the school should know, please write it in the space provided. (Include such things as eyesight, allergies and any special disability).

.....
Date

.....
Signature of Parent / Guardian