



ENTRY LEVEL _____

ENTRY DATE _____

STUDENT DETAILS

Full Name

_____ (Given Name) _____ (Family Name)

Place & Date of Birth _____ Present Age _____ Years

Gender ☐ Male ☐ Female (Please tick ☒)

Nationality _____ Religion _____

Language Spoken at Home _____

Other Language Spoken _____

Current Residential Address _____

House Phone Number _____

3 x 4
Photo

FAMILY INFORMATION

FATHER

Full Name _____

Nationality _____

Profession _____

Place of Employment _____

Email Address _____

Office Phone Number _____

Mobile Phone Number _____

MOTHER

Full Name _____

Nationality _____

Profession _____

Place of Employment _____

Email Address _____

Office Phone Number _____

Mobile Phone Number _____

SIBLINGS

Name	Age	School
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHILD'S PREVIOUS SCHOOL HISTORY

Grade	Year Attended	Name of School	Branch City, Country

Language of Instruction at previous school? (Please tick ☒)

☐ English ☐ Mandarin ☐ Bahasa Indonesia ☐ Other _____

a) Spoken English ☐ Fluent ☐ Fair ☐ Little ☐ None

b) Written English ☐ Fluent ☐ Fair ☐ Little ☐ None

If English is not the first language at home, how much formal instruction in English as your child had?

Has your child ever attended NationalHigh Jakarta School ? ☐ Yes ☐ No

Year attended : _____ At Level : _____

LEARNING AND BEHAVIORAL DETAILS

Has your child ever been diagnosed as having a learning-difficulty or had any special or remedial help in the past?

☐ Yes ☐ No Details : _____

Does your child have any behavioral traits or special needs of which the teacher be aware of?

☐ Yes ☐ No Details : _____

SPORTS, INTERESTS AND HOBBIES

Has your child ever shown special skill in sport games? Has he/she ever played for a school team?

☐ Yes ☐ No Details : _____

Does he/she have any particular hobby or musical ability?

☐ Yes ☐ No Details : _____

NOMINATED EMERGENCY CONTACTS (Non Parents in Jakarta known to the child)

1. Name : _____ Relationship : _____

Mobile Phone : _____ Home Phone : _____

2. Name : _____ Relationship : _____

Mobile Phone : _____ Home Phone : _____



DOCTOR'S NAME AND CLINIC

Doctor's Name and Clinic : _____

Address : _____

Phone : _____

STUDENT MEDICAL DETAILS

INFORMATION WHICH MAY BE CRUCIAL IN THE HANDLING OF AN EMERGENCY

Blood Type : _____ Rhesus : ☐ + ☐ - Weight : _____ Height : _____

Allergies (if any) : _____

Drug/Medication : _____ Foods : _____ Others : _____

History of anaphylaxis shock ☐ Yes ☐ No Epipen required? ☐ Yes ☐ No

Currently on medication? ☐ Yes ☐ No (If Yes, please list the name of medication)

Special recruitments ☐ Glasses ☐ Hearing Aid ☐ Wheel Chair / Crutchest

Diet preference ☐ Yes ☐ No

THE FOLLOWING HEALTH CONDITION CAN BE OF CONCERNED (Please indicate in the boxes provided)

- | | | |
|---|---|--|
| <input type="checkbox"/> Autoimmune (RA, SLE, Psoriasis) | <input type="checkbox"/> Heart Problem | <input type="checkbox"/> Urinary / Genitalia |
| <input type="checkbox"/> Ortopedic Problem (Backpain, Spine) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Problem (Eczema) |
| <input type="checkbox"/> Neurological Problem (Epilepsy, Seizure) | <input type="checkbox"/> Digestive Problem | <input type="checkbox"/> Dental Problem |
| <input type="checkbox"/> Blood Disorder (Thalasemia, Anemia, etc) | <input type="checkbox"/> Liver Disease (Hepatitis, etc) | <input type="checkbox"/> Surgery History |
| <input type="checkbox"/> Lung Disease (Asthma, Bronchitis) | | |

(If you have ticked any of boxes, please provide the details)

Please complete this information sheet

- | | |
|---|--|
| <input type="checkbox"/> Visual Problem | <input type="checkbox"/> Excessive weight gain or loss |
| <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Frequent Nose Bleeds |
| <input type="checkbox"/> Any problem with speech | <input type="checkbox"/> Faintings |
| <input type="checkbox"/> Physiological (ADHD, ADD, PTSD, Anxiety) | |

IMMUNIZATION RECORDS (Please attach copy of the records)

Please provide country of citizenship : _____

And dates of immunizations :

NAME OF VACCINE	DATE				
	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
BCG					
Hepatitis B					
DPT					
Polio					
MMR					
Hepatitis A					
Typhoid					
Corona					

ATTACHED DOCUMENTS

Kindly submit the following documents with the registration form :

- ☐ Registration Form
- ☐ A non-refundable registration fee
- ☐ Copy of birth certificate
- ☐ Four colour photographs of student (3x4 size)
- ☐ Transfer letter from previous school (if transferring from an Indonesian school)
- ☐ Copy of Kartu Keluarga or SKTTPS (for non-Indonesian citizen)
- ☐ Copy of parents' ID Card (KTP/Passport)
- ☐ Copy of parents KITAS/KIMS (for non-Indonesian citizen)
- ☐ Certified copy of immunization certificates (for students up to year 3)
- ☐ Any other information that may be required relevant to the student

STATEMENT

I certify that all statement in this REGISTRATION FORM is complete and true. I understand that any misinformation may result in denial of my application or dismissal from admission.

I will inform the school of any changes of these details, in the event of an accident, if neither I nor my emergency contact cannot be reached, I authorize the principal, or whoever he authorizes, to initiate emergency medical procedures deemed necessary.

Signature _____

Date _____

Parent's Name _____



NATIONALHIGH
JAKARTA SCHOOL