

PREVIOUS ACADEMIC RECORD

Name of the school with address	Class	Year of study	Grade obtained

ACHIEVEMENT OF THE CHILD

- _____
- _____
- _____

MEDICAL INFORMATION

Does your child have any of the following conditions?

Asthma Heart diseases Allergies Physical disabilities

PARENTAL RESPONSIBILITY

Please tick the box which is appropriate for your child:

Mother Mother & Father Father Grandparents Others

Father's Name: Academic Qualification:

Profession: Mob. No.

Mother's Name: Academic Qualification:

Profession: Mob. No.

Guardians Name(in the absence of parents):

Profession: Mob. No.:

KNOWING YOUR CHILD

Please tick the activities your child is interested in:

Games/Sports Drawing/Painting Singing/Dancing

Is your child right-handed or left-handed? _____

Does your child have a problem with vision? _____

If Yes, does the child wear glasses? _____

Signature of the Parent/Guardian

RESULT OF ADMISSION TEST**1. Written Test**

S.N.	Subject	Full Marks	Pass Marks	Marks Obtained	Remarks

INTERVIEW :-

Communication Skills.

General knowledge/Current affairs

IQ Test

Remarks

Principal's Signature