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Queensland Academy

1-5 Ebem-Oha Street, Off Okota Road, Isolo, Lagos.
Tel: 08033293480, 08037116570, 01-7227164, 8502499.
www.queenslandacademy.com

Affix two recent passport Photographs here

APPLICATION FOR ADMISSION

Surname ____________________

Forenames ____________________

Date of Birth ____________________

Place of Birth ____________________ Male/Female ____________________

Nationality ____________________ Religion ____________________

Name of Father ____________________

Occupation ____________________

Office Address ____________________

E-mail ____________________ Tel ____________________

Home Address ____________________

____________________ Tel ____________________

Name of Mother ____________________

Occupation ____________________

Office Address ____________________

E-mail ____________________ Tel ____________________

Home Address ____________________

____________________ Tel ____________________

Who will pay School Fees & Other Expenses ____________________

School Attended During the Last Year ____________________

One Close Contacts (Near the school) ____________________

Name ____________________

Address ____________________

Signed ____________________ Date ____________________

OFFICE USE ONLY

Reg. No. ____________________ School House ____________________

Admittance Date ____________________ Reg. Fee received ____________________

MEDICAL INFORMATION

A. Is your child/ward a sickler YES ☐ NO ☐

B. Is your child/ward a Asthmatic YES ☐ NO ☐

C. Has your child/ward any of the following defects
Eye ☐ Ear ☐ Nose bleeding ☐ None ☐

D. Has your child/ward any medical condition or any form of allergy that the school should Know about? ______________________________

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E. Has your child/ward ever been diagnosed as having specific learning difficuties such as Dyslexia, A.D.D or any other?

F. Has your child /ward been immunized against the following

1.	Small Pox	YES ☐	NO ☐
2.	Whooping cough	YES ☐	NO ☐
3.	Polio	YES ☐	NO ☐
4.	Tetanus	YES ☐	NO ☐
5.	Tuberculosis	YES ☐	NO ☐
6.	Mumps	YES ☐	NO ☐
7.	Rubella (German Measles)	YES ☐	NO ☐
8.	Hepatitis	YES ☐	NO ☐
9.	Meningitis	YES ☐	NO ☐

Please attach proof of immunization

G. In an emergency______________________________

Contacts Name______________________________

Address______________________________

Tel______________________________

Doctor______________________________

Contact Address______________________________

Tel. No.______________________________