

# GDS PRESCHOOL

## ADMISSION FORM

PHOTO  
(2 copies)

To,  
GDS PRESCHOOL

I wish to admit my ward in your institution. The details are as under :

Name : \_\_\_\_\_

Date of Birth : \_\_\_\_\_

Address : \_\_\_\_\_

\_\_\_\_\_ Tel.: \_\_\_\_\_

Father's Name : \_\_\_\_\_

Occupation : \_\_\_\_\_ Tel.: \_\_\_\_\_

Office Address : \_\_\_\_\_

Mother's Name : \_\_\_\_\_

Occupation : \_\_\_\_\_ Tel.: \_\_\_\_\_

Office Address : \_\_\_\_\_

Emergency contact person and Phone : \_\_\_\_\_

I have read all the rules and regulations as mentioned in the prospectus and agree to abide by them.

Signature  
(Parent / Guardian)

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### MEDICAL REPORT (To be filled by the family Doctor)

1. Name of Student : \_\_\_\_\_

2. a) Height \_\_\_\_\_ b) Weight \_\_\_\_\_ c) Chest \_\_\_\_\_

3. Identification Marks : \_\_\_\_\_

4. a) Inoculation taken on : \_\_\_\_\_

b) Vaccination taken on : \_\_\_\_\_

5. Blood Group : \_\_\_\_\_

6. i) Eyes : Refraction error / Trachome                      ii) Ears : Any discharge / Disease / Deafness

iii) Nose : Epistaxis - D.V.S.                                      iv) Tonsils : Chronic Enlargement

v) GIT : Appendicular colic / Any other colic                  vi) Hernia / Hydrocele

7. Any injury, illness or operation : \_\_\_\_\_

8. Allergy to Drug : Penicillin, Sulpha group, Quinine, Chloramphenicol, Terramycin, Any other drug

\_\_\_\_\_

9. Name of the Doctor : \_\_\_\_\_

Address \_\_\_\_\_ Tel.: \_\_\_\_\_

Signature  
(Parent / Guardian)

Signature  
(Doctor)