



## **Xi'an Hi-Tech International School** *The International Department*

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### **APPLICATION PACKAGE**

The complete application package consists of the following items:

- Students Application Form
- Family Information Form
- Medical Information Form
- School Report
- Permission to Release School Records

Before a final decision regarding admission can be reached, we must receive the School Reports and School Reports from the applicant's current school and all the forms included in the Application Package must be completed and submitted.

There will also be an initial interview between the parents and the Principal, a student/teacher interview and informal assessment, a student classroom visit (when possible), and a conference between the Principal and parents. Whenever feasible the interviews and conferences will be held in person.

## STUDENT APPLICATION

Student's Name: \_\_\_\_\_ Gender:  Male  Female  
(Family Name, First Name, Middle Name)

Date of birth \_\_\_\_\_ Citizenship: \_\_\_\_\_ Passport No: \_\_\_\_\_

Expected date of enrollment: \_\_\_\_\_ Last grade completed: \_\_\_\_\_ Applying for year: \_\_\_\_\_

Address in Xi'an: \_\_\_\_\_ Parents email Add: \_\_\_\_\_

### EDUCATIONAL BACKGROUND

#### Other schools attended

Please list all schools attended beginning with the most recently attended. School records from the most recently attended school must be submitted.

	Name of School	Location (City, Country)	year(s)	Language	Dates Attended
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

Academic Strengths: \_\_\_\_\_

Academic Weaknesses: \_\_\_\_\_

Has the student repeated any years? \_\_\_\_\_ if "yes", which? \_\_\_\_\_

Please explain: \_\_\_\_\_

\_\_\_\_\_

Has the student ever been requested to leave school? \_\_\_\_\_

If "yes, please explain: \_\_\_\_\_

Has the student ever attended special education classes or school for students with learning/physical/emotional difficulties? \_\_\_\_\_

Please explain: \_\_\_\_\_

Does the student have any health or physical problems? \_\_\_\_\_

Please explain: \_\_\_\_\_

Primary language spoken in the home: \_\_\_\_\_

Student's first language: \_\_\_\_\_

Student's other languages: \_\_\_\_\_

Number of years, if any, that the student has lived outside his/her native country: \_\_\_\_\_

**ACTIVES AND SPECIAL INTERESTS**

Please list the student's special interests, hobbies, talents, etc.

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**OTHER INFORMATION**

Please list any other information about the student that would be helpful in making his/her experience at XHIS as rewarding as possible:

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Name of person completing this application: \_\_\_\_\_ Signature: \_\_\_\_\_

Relations to student: \_\_\_\_\_

Date of application: \_\_\_\_\_

**FAMILY INFORMATION FORM**

Father's name: \_\_\_\_\_  
(Family Name, Given Name)

Mather's name: \_\_\_\_\_  
(Family Name, Given Name)

Xi'an address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Xi'an address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home telephone: \_\_\_\_\_

Home telephone: \_\_\_\_\_

Mobile telephone: \_\_\_\_\_

Mobile telephone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

E-mail address: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Occupation: \_\_\_\_\_

Occupation: \_\_\_\_\_

Company/organization: \_\_\_\_\_

Company/organization: \_\_\_\_\_

Company's Address in Xian: \_\_\_\_\_

Company's Address in Xian: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Business telephone: \_\_\_\_\_

Business telephone: \_\_\_\_\_

Business Fax No: \_\_\_\_\_

Business Fax No: \_\_\_\_\_

**SIBLINGS' INFORMATION**

Name	Date of Birth
_____	_____
_____	_____
_____	_____

**GUARDIAN** *(if student not residing with parents)*

Name: \_\_\_\_\_ gender:  Male  Female

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

Telephone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**IN CASE OF EMERGENCY**

Person(s) in Xi'an to contact in an **emergency** if parents are not available.

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

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

**PAYMENT OF FEES**

School fees will be paid by :  Parents  Company  Guardian

Bills should be mailed to :  Home  Company

## Medical information Form

The information in this form is required to assure the health and safety of everyone our school. All the questions below must be answered. The information provided herein will be kept confidential except as it may be shared according to school policy.

**Please note: No student will be allowed to attend classes unless a completed Medical information Form has been submitted to the school.**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### EMERGENCY TREATMENT

Emergency Contact phone Numbers

Local physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mother : \_\_\_\_\_ Home Number: \_\_\_\_\_

Work phone: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

Father: \_\_\_\_\_ Home Number: \_\_\_\_\_

Work phone: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

Back up: \_\_\_\_\_ Home Number: \_\_\_\_\_

Local physician: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

In the event the parents or legal guardians named on this form cannot be contacted, I the undersigned do hereby authorize the officials of the Xi'an Hi-Tech international school to obtain emergency medical treatment for the health of \_\_\_\_\_

(Print Student's Name)

I will not hold the school responsible for the emergency care and or transportation for said student.

Sighed: \_\_\_\_\_ Date: \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insured Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Company: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**BRIEF MEDICAL HISTORY**

Allergic to these medications: \_\_\_\_\_

Type of reaction: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies to foods, inserts, etc: \_\_\_\_\_

Type of reaction: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please check if your child has any of the following:

Airborne Allergies

Cardiac Problems

Asthma Kidney

Problems

Diabetes

Migraines

Other (please specify) \_\_\_\_\_

Treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your child has his/her eyes tests? If yes, when was the last time? \_\_\_\_\_

Does your child wear glass?

Has your child has his/her ears tests? If yes, when was the last time? \_\_\_\_\_

Does your child has any hearing problem?

Has your child ever been diagnosed as having any learning or behaviour disorders?

If yes, please give details including any treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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### VACCINATION RECORD

Please complete the chart below; alternatively, attach the student's vaccination record. Note that students who have not received the all these vaccinations may still be admitted however, in the event of the occurrence of any of these illnesses students who have not received the appropriate vaccination will not be allowed to attend classes.

<b>Vaccination</b>	<b>Date of First Vaccination</b>	<b>Date of First Booster</b>	<b>Date of Second Booster</b>
<b>Diphtheria, Tetanus, Pertussis</b>			
<b>Poliovirus</b>			
<b>Measles, Mumps, Rubella</b>			
<b>Hepatitis A</b>			
<b>Hepatitis B</b>			
<b>Varicella</b>			
<b>Haemophilus Influenza Type B</b>			
<b>Japanese Encephalitis</b>			
<b>Pneumococcal</b>			
<b>Influenza</b>			

### MEDICAL DECLARATIONS

I hereby confirm that to the best of my knowledge, none of my family are suffering from any contagious or infectious diseases on the date of signature. I understand that the term "contagious and infectious diseases" include, but is not limited to: measles, mumps, rubella, chicken pox, SARS, hepatitis A ,hepatitis B, and whooping cough.

I further undertake to inform the Dean or principal (or deputy) if any of my family or of my domestic employees contracts such a disease, and will act according to the school's requirements in such a case.

I understand that these requirements may include isolation at home for one or more infected or at-risk family members or domestic employees in the health interests of the school community. I agree to have my family undergo medical checks at the expense of the expense of the family, to certify that return to school is safe by a medical practitioner.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby declare, that to the best of my knowledge, my child is in good health and physically able to participate in all school activities with the following restrictions: \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **AUTHORIZATION TO ADMINISTER MEDICATION**

In order assure the safety of our students and to prevent misuse of prescription medicines, students are not permitted to have any prescription or non-prescription drugs in their possession. (see below for exceptions). In cases where it is necessary for them to take any medication during school hours the medicine should be given to the classroom teacher with instructions from home and administered by the classroom teacher. This includes administering medicine prescribed by your medical practitioner.

Please complete the waiver from below, which clears responsibility for the XHIS to administer prescription medicine, at your request.

For each condition, you must in addition provide a copy of your child's prescription, the doctor's instructions in writing in case of any emergency, and one written letter providing care instructions from you to authorize the nurse to give your child's medication during school hours. Without the above, the XHIS nurse will not instigate treatment.

I authorize the XHIS staff to take all necessary medical action to ensure my child's well being while in school. This includes the administering of medication, both orally and via syringe, as outlines in the care instructions I shall provide to the nurse.

Student's Name: \_\_\_\_\_ parent's/Guardian's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please note that this release will be valid for the entire period in which your child remains enrolled in XHIS unless revoked in writing.

**SELF –ADMINISTRATED MEDICATION PERMISSION FORM**

Permission for Self-administrated Medication is effective only for students who have one or more of the following conditions:

- Asthma medication
- severe anaphylactic reactions medication such as epi-pen
- Diabetic emergency medication and regular blood sugar checking

Permission for self-administration of medications effective only for the school year when granted and must be renewed annually.

This permission allows the pupil with n\one or more of the above mentioned conditions to “possess and use his /her medication( i )while in school,(ii )while at a school sponsored activity, (iv)while under the supervision of school personnel, or (iv)before or after normal school activities while on School-operated property.”

Name of Medication:\_\_\_\_\_

Directions for Use (include time(s) or special circumstances under which the medication is to be administered and the dosage):

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I confirm that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency ,I hereby authorized my child in my behalf and stead ,to self-administer the medicine , while under the supervision of the employees and agents of Xi’an Hi-Tech International School, it’s as possible ,the lawfully prescribed medication(s) as described above . I further acknowledge and agree that ,when the lawfully prescribed medications is so administered or attempted to be administered, I waive any claims might have against XHIS, Its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify Xi’an Hi-Tech International School , its employees and agents, either jointly or severally, from and against any and all claims ,damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication(s).

Parent’s /Guardian’s Name: \_\_\_\_\_ parent’s/Guardian’s signature:\_\_\_\_\_

Date: \_\_\_\_\_