

IVY FIRST PRE-PRIMARY SCHOOL



Registration No. EM 17696

P.O.BOX 36038, DAR ES SALAAM, KIGAMBONI

Contacts: +255 757 676 808 E-mail: ivyfirstschool@gmail.com

Child's Photo

Father's Photo

Mother's Photo

APPLICATION FORM FOR ACADEMIC YEAR 2027

Please read the school Rules and Regulations on page 6 of the joining instructions before completing this form. By completing and signing this form, you agree to the terms and conditions and acknowledge that any breach of school rules by your child will result in disciplinary action.

PART 1 *(To be completed by parent/Authorized person)*

A. CHILD'S DETAILS

Child's first name	Middle name	Last name

Class applied for Year of entry

Gender: ☐ Boy ☐ Girl

Date of Birth ____/____/____ *(Please attach the copy of the birth certificate)*

Nationality	Place of birth/Region/District

B. PARENT'S PARTICULARS *(briefly explain the location of your home place):*

.....
Name of any famous place/site near your home.....

Father's name and full address	Name: Address: P. O. Box..... Phone No: (1)..... (2).....
Mother's name and full address	Name: Address: P. O. Box Phone No: (1) (2)

Parental responsibility	Mother*/Father*/Both*/Guardian*/ (please indicate)
With whom does the child live?	

C. MODE OF TRANSPORT

Please circle the main mode of transport that will be used by your child! (Public bus/school bus/private/walk/other (please specify) State the distance from your home to school in Km
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D. ACADEMIC BACKGROUND

Did he/she attend any school? YES ☐ NO ☐

If yes, for how long? And what is the school's name?

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If he/she is transferring, please attach the transfer details from the previous school. That is, the student Academic Development Card and Premo Number.

E. HEALTH HISTORY (Attach the Dr. Medical Prescription Form)

Any severe illness/allergy that caught a child that troubles him/her (*please indicate if any*)

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[Attach the health checkup form or any other doctor verifications]

F. PARENT / GUARDIAN DECLARATION AND AGREEMENT

I, the undersigned parent/legal guardian, declare and confirm that:

1. I have read and understood the Ivy First Pre & Primary School Rules and Regulations on page 6 of the 2027 Joining Instructions before completing this application form.
2. I understand and agree that, by signing this form, I accept the school's rules, regulations, admission conditions and relevant policies as stated in the Joining Instructions.
3. I understand that my child is expected to observe the school's Christian values and ethics, attend morning devotion, attend school regularly, respect staff and other pupils, use English as the medium of communication on school premises, and follow the school's behavior, punctuality, uniform and safety requirements.
4. I understand that breaches of school rules may result in the corrective procedures described in the Joining Instructions.

5. I confirm that all information provided in this application and its attachments are true and complete to the best of my knowledge. I will inform the school of any material changes, particularly contact, health or emergency information.
6. I understand that the application is subject to the school's admission process and that submission of this form does not by itself guarantee admission.

Parent / Guardian	Full name	Signature	Date
Father/ Guardian 1			
Mother/ Guardian 2			

PART 2 (*For official use only*)

This child is fit for class:under the supervision of class teacherbasing on the school's terms and conditions.

Signature of the principal Date

STUDENT MEDICAL CERTIFICATE

Please complete a medical check-up at a hospital of your choice.

NAME OF STUDENT: _____

BLOOD GROUP

Put a circle (o) on 'YES' if the student has problems with the items in the list.

Circle (o) 'NO' if there are no problems. Please write the problems in detail if the circle is on 'yes'

QUESTIONS 1	Sight	YES	NO
	If yes, state		
QUESTIONS 2	Hearing	YES	NO
	If yes, state		
QUESTION 3	Speech	YES	NO
	If yes, state		
QUESTION 4	TB	YES	NO
	If yes, state		
QUESTION 5	Blood Pressure	YES	NO
	If yes, state		
QUESTION 6	Asthma	YES	NO
	If yes, state		
QUESTION 7	Any other health problem (example: HIV) _____	YES	NO
	If yes, state		
QUESTION 8	Any other physical disability	YES	NO
	If yes, state		
NAME OF HOSPITAL:		DOCTOR NAME:	
DATE:		SIGNATURE AND STAMP:	