



For Official use	
REF	
DOA	

## APPLICATION FOR ADMISSION

### A. CHILD'S PERSONAL PARTICULARS

Full Name <i>As in BC/ NRIC; Underline Surname</i>		Chinese Name if Applicable		AFFIX CHILD'S PHOTOGRAPH HERE
BC/NRIC No.	Date of Birth	Age		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Country of Birth	Citizenship		
Race	Religion	Home Language(s)		
Residential Address				
Contact No.	Child Staying with Parent(s) <input type="checkbox"/> Yes <input type="checkbox"/> No*	Main Caregiver During the Day		

### B. FAMILY INFORMATION

<b>FATHER'S PERSONAL PARTICULARS</b>				
Full Name		NRIC No.		Date of Birth
Citizenship		Race		Religion
Educational Qualification		Occupation		Spoken Language(s)
Nett Monthly Income*	<input type="checkbox"/> No Income	<input type="checkbox"/> \$1000 or below	<input type="checkbox"/> \$1001 - 1500	<input type="checkbox"/> \$1501 - 2000
	<input type="checkbox"/> \$2001 - 2500	<input type="checkbox"/> \$2501 - 3000	<input type="checkbox"/> \$3001- 5000	<input type="checkbox"/> \$5001 & above
Residential Address (If different from above)				
Contact No.	Home	Office	Handphone	
<b>MOTHER'S PERSONAL PARTICULARS</b>				
Full Name		NRIC No.		Date of Birth
Citizenship		Race		Religion
Educational Qualification		Occupation		Spoken Language(s)
Nett Monthly Income*	<input type="checkbox"/> No Income	<input type="checkbox"/> \$1000 or below	<input type="checkbox"/> \$1001 - 1500	<input type="checkbox"/> \$1501 - 2000
	<input type="checkbox"/> \$2001 - 2500	<input type="checkbox"/> \$2501 - 3000	<input type="checkbox"/> \$3001- 5000	<input type="checkbox"/> \$5001 & above
Residential Address (If different from above)				
Contact No.	Home	Office	Handphone	

\*Please tick the appropriate boxes

<b>PARTICULARS OF GUARDIAN/ CAREGIVER/ RESIDENTIAL HOME</b> <i>(If child is not in the care of parents)</i>			
Full Name	NRIC No.		Relationship/ Designation
Age	Race		Religion
Occupation	Spoken Language(s)		
Address			
Contact No.	Home	Office	Handphone

<b>PARTICULARS OF SIBLINGS &amp; ANY OTHER RELATIVES STAYING WITH THE FAMILY</b>			
Name	Relationship	Date of Birth	School/ Occupation <i>(State monthly income if working)</i>

**C. INFORMATION ABOUT CHILD**

<b>EDUCATIONAL BACKGROUND</b>			
School/ Kindergarden	Year Attended		Highest Standard Attained
	From	To	

<b>ACTIVITIES FOR DAILY LIVING SKILLS *</b>		
Feeding	<input type="checkbox"/> I <input type="checkbox"/> P <input type="checkbox"/> A <input type="checkbox"/> D	Key: I - Independent P - Partial Assistance A - Aid Required D - Totally Dependent
Bathing	<input type="checkbox"/> I <input type="checkbox"/> P <input type="checkbox"/> A <input type="checkbox"/> D	
Dressing/ Grooming	<input type="checkbox"/> I <input type="checkbox"/> P <input type="checkbox"/> A <input type="checkbox"/> D	
Toileting	<input type="checkbox"/> I <input type="checkbox"/> P <input type="checkbox"/> A <input type="checkbox"/> D	
Mobility	<input type="checkbox"/> I <input type="checkbox"/> P <input type="checkbox"/> A <input type="checkbox"/> D	

<b>CHILD'S MEANS OF COMMUNICATION *</b>		
<input type="checkbox"/> Verbal	<input type="checkbox"/> Written	<input type="checkbox"/> Others <i>(Please Specify):</i>

*\*Please tick the appropriate boxes*





## MEDICAL REPORT

*To be completed by a qualified medical practitioner*

### A. CHILD'S PARTICULARS

Full Name	NRIC No.	Date of Birth
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female *	Race	Blood Group

### B. BIRTH HISTORY & DEVELOPMENT MILESTONES


### C. MEDICAL BACKGROUND

<b>Past Medical History</b>		
<b>Current Medical Problem/ Diagnosis</b>		
<b>Cause(s) &amp; Onset of Disability</b>		
Is child currently on medication? *	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please specify:</i>		
Does child have any allergy? *	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please specify:</i>		
Does child have any diagnosis of psychiatric disorder? *	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please specify:</i>		

### D. FAMILY HISTORY

Any family member with mental disabilities? *	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please specify:</i>		

*\*Please tick the appropriate boxes*

### E. PHYSICAL EXAMINATION

Height		Weight		Head Circumference			
Dysmorphic features							
Heart							
Lungs							
Musculoskeletal System							
CNS							
<b>Hearing</b>							
Has child had a formal hearing test? *				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<i>If yes, please specify date:</i>							
Is child's hearing within normal limits? *				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<i>If no, please specify details:</i>							
Right ear drum	Left ear drum						
<b>Vision</b>							
Has child had a formal vision test? *				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<i>If yes, please specify date:</i>							
Is child's vision within normal limits? *				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<i>If no, please specify details:</i>							
R 6/ _____	Squint? *			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
L 6/ _____	Astigmatism? *			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

### F. REMARKS & RECOMMENDATIONS


<b>EXAMINED BY:</b>		
Name of Doctor	Signature	Date
Hospital/ Clinic (Official stamp)	Contact No.	

*\*Please tick the appropriate boxes*