VIRGEN DEL PILAR SCHOOL
SISTERS OF CHARITY OF ST. ANNE
ILOILO STREET, RODRIGUEZ, RIZAL

A. No._____

Attach 1x1 photo here

APPLICATION / INFORMATION FORM S.Y. 201__ to 201__
[Nursery to Grade 6]

USE CAPITAL LETTERS. ONLY APPLICATION ACCOMPLISHED CORRECTLY AND COMPLETELY WILL BE PROCESSED

NAME OF APPLICANT_____ _____ _____
(Last) (First) (Middle)

LEVEL_____ DATE OF BIRTH_____ PLACE OF BIRTH_____

AGE BY JUNE_____ NATIONALITY_____

RELIGION _____ DATE OF BAPTISM_____PARISH_____

PRESENT HOME ADDRESS_____

_____

TEL NO: _____MOBILE NO: _____

FATHER		MOTHER
	NAME	
	CITIZENSHIP	
	RELIGION	
	HOME ADDRESS	
	E-MAIL ADDRESS	
	TEL.NO. & MOBILE NO.	
	OCCUPATION	
	EDUCATIONAL STATUS	

Brothers/ Sisters studying in Virgen Del Pilar School [Write the name and level]

1.
2.
3.
4.

NAME OF GUARDIAN:_____ Tel. No: _____

WE HEREBY CERTIFY THAT ALL INFORMATION FURNISHED HEREIN IS ACCURATE. IF ADMITTED WE ARE WILLING TO ABIDE BY THE RULES AND REGULATIONS OF THIS SCHOOL AND ACCEPT THE NORMS OF DISCIPLINE AND OTHER SCHOOL ACTIVITIES WE WILL BE ASKED TO UNDERTAKE.

Signed this _____ day of _____ 201_

_____ _____
Father's Signature Mother's Signature

VIRGEN DEL PILAR SCHOOL RODRIGUEZ, INC.
Sisters of Charity of St. Anne
Iloilo Street, Burgos, Rodriguez, Rizal
Tel. No: +63 (2) 997-76-14 | +63 (2) 941-01-21 | Fax No: +63 (2) 997 -76-15 | Email: info@virgendelpilarschool.com
www.VirgenDelPilarSchool.com

GUIDANCE AND COUNSELLING RECORD

SCHOOL YEAR 201__ - 201__

NAME:_____

LEVEL:_____ DATE OF BIRTH:_____

FATHER:_____MOTHER:_____

PRESENT HOME ADDRESS_____

_____

TEL NO: _____MOBILE NO: _____

PLEASE DESCRIBE YOUR CHILD: (CHECK THE APPLICABLE)

____FRIENDLY ____OUT GOING ____ACTIVE ____QUIET

____COOPERATIVE ____STUBBORN ____SHY ____PATIENT

____NERVOUS ____MOODY ____EXCITABLE ____HAPPY

____FEELS INSECURE ____SELFISH ____INDEPENDENT ____AGGRESSIVE

____GETS ALONG WITH OTHERS ____HAS TANTRUMS

____FAST LEARNER ____SLOW LEARNER

PLEASE CHECK THE HAND USE:

LEFT HANDED _____ YES ____NO

TIME SPEND WITH THE CHILD PER DAY:

FATHER_____HOURS MOTHER_____ HOURS

Signed this _____ day of _____ 201__

_____ _____

Father's Signature Mother's Signature

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STUDENT HEALTH RECORD

S.Y. 201__ – 201__

NAME: _____
LEVEL_____DATE OF BIRTH _____
CHILD'S PLACE IN THE FAMILY_____
HOME ADDRESS_____
_____Phone No/Mobile No:_____
FATHER:_____MOTHER:_____
OFFICE TEL. NO. OF FATHER_____ MOTHER_____

IN CASE OF EMERGENCY NOTIFY TO:
NAME_____
RELATION_____ TEL.NO._____

IMMUNIZATION RECORD:[Write the date of dosage]
BCG_____ (Anti T.B.)
DPT_____ (Diphtheria, Pneumonia, Typhoid)
OPV_____ (Polio)
_____ Measles vaccine

PAST MEDICAL HISTORY:[Check the applicable]

___Measles	____ Allergies	___ Epilepsy
___Mumps	____ Bronchitis	___ Psychoneurosis
___German measles	____ Heart disorder	___ Hepatitis
___Chicken pox	____ Kidney disorder	___ Convulsions
	____ Operations	

CHECK IF STUDENT SUFFERS FREQUENTLY FROM THE FOLLLOWING:

___ Colds	____ Stomach upset	____Earache
___ Frequent headache	____ Nose Bleed	____Vomitting
___ Diarrhea	____Dizziness	____Abdominal pain

Sisters / Brothers in the School:
Name_____ Level_____

Name_____ Level_____

Name_____ Level_____

Name_____ Level_____

Signed this _____ day of _____ 201__

_____ _____
Father's Signature Mother's Signature

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