Myanmar International School

No. 20, Pyin Nya Waddy Street, Yankin Township, Yangon
Tel: 95 1 558115~118 **Fax: 95 1 558109**
Email: info@mis-edu.com **Website: www.mis-edu.com**

Student information

Name: _____ Preferred Name (if any): _____

First Middle Last

☐Male ☐Female Date of Birth: _____ Current Age: ___ Years ___ Months
(DD/MM/YY)

Nationality: _____ Passport / NRC no: _____Last Year/Grade Lever Completed ____

Brother / sister currently studying at MIS: _____Year: _____

Parent's Information

Father's Name:	Mother's Name:
Nationality:	Nationality:
Telephone:	Telephone:
Email:	Email:
Children are living with: ☐Both Parents ☐Father ☐Mother ☐Guardian	
If Guardian: Name:	
Phone:	Email:

Schools attended:

Name of school	Year / Grade	Attended from (MM/YY)	To (MM/YY)	Language of instruction

----------Official Use Only----------

Placement test:

Date:
Time:
Level:

Meets MIS Entry Requirement for Year: _____

Class/teacher Assigned: _____

Admissions Form Completed		Two Photos (Parent & Student)	
Previous School Records Submitted		Birth Certificate/Passport copy	
MIS Information Medical Form Completed		Fee Paid	
Medical Records Submitted			

MYANMAR INTERNATIONAL SCHOOL: MEDICAL INFORMATION

Student's Full Name _____ Class_____

Does your child suffer from any of the following conditions? (Tick those which apply)

Asthma		Diabetes	
Chest problems		Fainting	
Epilepsy/Seizure		Migraine	
Heart problem		High Blood Pressure	
Disability		Allergy or Intolerance	
Other			

If you have ticked any of the above, please provide details, including of any hospitalization

Immunisation Status
Has your child been fully vaccinated against?

MMR (Measles, Mumps and Rubella)	Yes/No	Hepatitis B	Yes/No
BCG (against Tuberculosis/TB)	Yes/No	OPV(Polio)	Yes/No
DTP (Diphtheria, Tetanus and Whooping Cough)	Yes/No		

Does your child suffer from any other condition requiring medication? YES / NO
If YES, please provide details:

Is your child allergic or sensitive to any food, medication, insect bites or stings? YES / NO
If YES, please provide details:

Is your child taking any form of medication on a regular basis? YES / NO
If YES, please provide details:

Does your child need to wear glasses or hearing aids? YES /NO

If YES, please provide details:

When did your child last have his/her eyes tested? _____
(If longer than 12 months, please have them tested by an optician.)

Dietary Information
Does your child have any special dietary needs?

Vegetarian		Halal		No beef		Other (please state)	

Emergency treatment
The School will contact you as soon as possible should an emergency occur but please sign to confirm that you give permission for the school to administer any urgent medical treatment that is required and to take the child to hospital.

Emergency Care Provider
If there is a particular hospital or ambulance service we should call in the event of an emergency, please give details here.

Parent's signature _____ Date _____