

Attach student photo here



# West Nairobi School

P.O. Box 1333  
Nairobi, Karen 00502  
Kenya

Tel. 254-20-884905/6 [info@westnairobischool.org](mailto:info@westnairobischool.org)



## APPLICATION FOR ADMISSION

- Enrollment Fee - \$100
- Registration Deposit - \$200
- Attach Grade Report/School Records from 2 previous years (except for Kindergarten applicants)
- Attach Birth Certificate/Proof of Birth Date
- Attach health/vaccination record
- Attach photo page of Passport/Dependents Pass page/Pupils Pass page
- If standardized or educational testing results are available please attach
- If student has been assessed or placed in any special education programs, attach IEP

Pupil's Name: \_\_\_\_\_  
Last First Middle Name Used

Grade and Date of Requested Entrance: \_\_\_\_\_ Bus Transport Needed? Y / N (circle one)  
Grade Date

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_ Birthplace: \_\_\_\_\_  
Month Day Year City Country

Citizenship: \_\_\_\_\_ Passport Number: \_\_\_\_\_ SS#(U.S.) \_\_\_\_/\_\_\_\_/\_\_\_\_

Issue Date: \_\_\_\_\_ Expiry Date: \_\_\_\_\_ (Please provide photocopy of passport)

Authority to be in Kenya (circle one) Dependent Pass Pupil Pass Other (list) \_\_\_\_\_

Kenya Address: \_\_\_\_\_  
P.O. Box City Postal Code

Home Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Email address (1): \_\_\_\_\_ Email address (2): \_\_\_\_\_

Father's Name: \_\_\_\_\_  
Last First Mobile Phone #

Birthplace: \_\_\_\_\_ Nationality: \_\_\_\_\_

Citizenship: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Country

Employer \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employers Address: \_\_\_\_\_  
P.O. Box or Street name and number City State Country

Mother's Name: \_\_\_\_\_  
Last First Mobile Phone #

Birthplace: \_\_\_\_\_ Nationality: \_\_\_\_\_

Citizenship: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Country

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employers Address: \_\_\_\_\_  
P.O. Box or Street name and number City State Country

Parents' Religious Affiliation: \_\_\_\_\_

**PREVIOUS TWO YEARS OF SCHOOLING**

NAME OF SCHOOL \_\_\_\_\_

ADDRESS \_\_\_\_\_

Grade(s) \_\_\_\_\_ Dates \_\_\_\_\_

NAME OF SCHOOL \_\_\_\_\_

ADDRESS \_\_\_\_\_

Grade (s) \_\_\_\_\_ Dates \_\_\_\_\_

Has the applicant had any history of learning difficulty? \_\_\_\_\_ Ever received specialized education? \_\_\_\_\_ Ever been diagnosed as having Attention Deficit Disorder? \_\_\_\_\_ If the answer is "yes" to any question, please explain and supply all diagnostic results. Etc. (Please note that WNS is glad to admit and work with children with minor learning problems, but does not have a program nor personnel to care for children with serious learning problems.)

**REFERENCES and EMERGENCY CONTACTS (Within Nairobi when possible):**

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Mobile # \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Mobile # \_\_\_\_\_

3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Mobile # \_\_\_\_\_

**PLEASE NOTE:**

Pupils are subject to such discipline as may be thought necessary, or to expulsion should they be habitually disobedient.

The use or possession of tobacco and/or alcoholic beverages is forbidden.

All communications should be addressed to: West Nairobi School, P.O. Box 1333, Nairobi Karen 00502, Kenya or info@westnairobischool.org

**SPECIAL NOTE: FOR STUDENTS ENROLLING IN WEST NAIROBI SCHOOL, A U.S. \$200 TUITION REGISTRATION DEPOSIT IS TO BE INCLUDED WITH THIS FORM. THESE DEPOSITS ARE NON-REFUNDABLE BUT WILL BE FULLY APPLIED TO TUITION.**

**GENERAL STATEMENT**

I hereby certify that the above particulars are correct. I am aware that the West Nairobi School follows the American course of studies. I permit my child full participation in all activities including religious instruction, which West Nairobi School includes in its curriculum.

Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

\_\_\_\_\_  
Parent's signature

\_\_\_\_\_  
Parent's signature

Application must be filled out completely before students will be allowed to attend classes. Please be thorough.

# REPORT OF HEALTH EXAMINATION

## West Nairobi School

TO PROTECT THE HEALTH OF CHILDREN, WNS REQUIRES A HEALTH EXAMINATION ON SCHOOL ENTRY. PLEASE HAVE THIS REPORT FILLED OUT BY A HEALTH EXAMINER AND RETURN IT TO THE SCHOOL. THE SCHOOL WILL KEEP AND MAINTAIN IT AS CONFIDENTIAL INFORMATION

<b>PART 1</b>	<b>TO BE FILLED OUT BY PARENT OR GUARDIAN</b>
<b>CHILD'S NAME:</b> _____ <b>Birthdate:</b> _____ <b>Blood Type:</b> _____ <b>Approx. Wt:</b> _____ <span style="display: block; text-align: center; font-size: small;">(Last) (First) (Middle) (Day/Month/Year)</span>	
<b>ADDRESS:</b> _____ <span style="display: block; text-align: center; font-size: small;">P.O. Box City</span>	

<b>PART 2</b> <b>HEALTH EXAMINATION Date:</b> _____	<b>PART 3</b> <b>IMMUNIZATION RECORD</b>
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Required Tests and Evaluations	Check When Completed	Vaccine	Date Each Dose Was Given				
			1st	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>
Health and Developmental History		Polio ((TOP/IPV0 (circle one))*					
Physical Evaluation		DPT/Td/DT (circle one)*					
Tuberculin Test (BCG)		Measles					* Required at West Nairobi School
Other:		Rubella*					
Other:		Mumps					

*I give my permission to West Nairobi School personnel to administer the following non-prescription medications to my child if deemed necessary.*

Please check the non-prescription medications you give permission for:

Actal or Buscopan or Eno (for stomach discomfort)  
  Ear Drops  
  Throat Lozenges  
  Panadol or Tylenol  
  Eye Drops  
 Anti-Diarrheal Medication  
  Piriton (for allergic reactions)  
 Other? \_\_\_\_\_

In the event when "NO WARNING" civil disorder occurs during the school day, thus prohibiting safe travel, I give West Nairobi School authority to assume custody of my child for a maximum "24-hour period" without liability to West Nairobi School.

*Contact or Transport Student to: (response required)*

Doctor's Name: \_\_\_\_\_ Dr's Phone #: \_\_\_\_\_ Hospital: \_\_\_\_\_  
 Hospital Phone #: \_\_\_\_\_ Parent or Guardian Signature: \_\_\_\_\_

- All test and evaluations must be done after the child is 4 ½ years of age.

<b>PART 4</b> <b><u>ADDITIONAL INFORMATION FROM HEALTH EXAMINER</u></b> To the best of my knowledge: 1. The above named student is free of infection and contagious diseases and can participate in normal school activities <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, state conditions or limitations _____ _____ _____	2. The following conditions are relevant to schooling and should be considered by the school or may need further evaluation. Follow-up is the responsibility of the parent or guardian (e.g., allergies, asthma, medications, etc.) _____ Name, address, and phone number of health examiner: _____ _____ Signature and stamp of Health Examiner _____ Date _____
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Does your child have any visual or hearing impairments requiring any adaptations for the classroom? If so please state.

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Does your child have any of the following health related conditions?  
 Diabetes? \_\_\_\_\_ Asthma? \_\_\_\_\_ Epilepsy? \_\_\_\_\_ Other? \_\_\_\_\_

Is your child taking any medications regularly at home?  
 Yes  
 No  
 If yes, please give the name, dosage and purpose of the medication:

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Reaction to bee stings?  
 Mild   
 Moderate   
 Severe   
 Additional parent health comments on back.