BEEHIVE SCHOOL

LIST OF REQUIREMENTS FOR NEW ADMISSION

- PAY AN APPLICATION FEE OF GHC 50.00

ADDITIONAL INFORMATION

- TWO PASSPORT SIZE PICTURES

- COPY OF BIRTH CERTIFICATE OR RELEVANT PAGE OF PASSPORT

- COPY OF IMMUNIZATION RECORDS

- TWO TERMINAL REPORT FROM PREVIOUS SCHOOL (*IF APPLICBLE*)

LOCATION: OFF THE ADENTA AVIATION ROAD OR ALTERNATIVELY ON THE ASHALEY BOTWE ROAD OFF "PEACE BE" JUNCTION
EMAIL: beehiveschoolmail@gmail.com
OPEN: 6:30AM – 4:00PM
CLOSED: ON HOLIDAYS
CONTACT: 0266010469/0265118473/0302915203

APPLICATION FORM

LOCATION: OFF THE ADENTA AVIATION ROAD OR ALTERNATIVELY ON THE ASHALEY BOTWE ROAD OFF "PEACE BE" JUNCTION
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CHILD INFORMATION

NAME OF CHILD:

Surname, First name

DATE OF BIRTH:

Dd/mm/yy (eg. 7th December 2019)

SEX: M F

HEIGHT:

WEIGHT:

NATIONALITY:

STREET NAME:

CITY:

RELIGION:

PREVIOUS SCHOOL ATTENDED	CLASS AND YEAR
1. ……	……
2. ……	……
3. ……	……
4. ……	……

MOTHER/FEMALE GUARDIAN INFORMATION

NAME:

Surname, First name

PHONE NUMBER

POSTAL ADDRESS

E-MAIL ADDRESS

OCCUPATION

WORK ADDRESS

LOCATION

WORK PHONE NUMBER

FATHER/MALE GUARDIAN INFORMATION

NAME:

Surname, First name

PHONE NUMBER

POSTAL ADDRESS

E-MAIL ADDRESS

OCCUPATION

WORK ADDRESS

LOCATION

WORK PHONE NUMBER

PERSONS TO NOTIFY IN CASE OF EMERGENCY/AUTHORIZED TO PICK UP

NAME:

RELATION:

PHONE NUMBER

POSTAL ADDRESS

E-MAIL ADDRESS

OCCUPATION

WORK ADDRESS

LOCATION

WORK PHONE NUMBER

BEEHIVE SCHOOL

MEDICAL HISTORY FORM
(TO BE FILLED BY PARENT/GUARDIAN)

1. Name of Student ……

Date of Birth…… Height……..Weight……

2. Does he/she suffer from sickle-cell disease?……

Asthma? ……

Any digestive trouble? ……

Any other conditions which may need attention? ……

3. Has he/she had any operation at any time in his/her life? YES NO

If yes, what and when? ……

From which doctor did he/she receive treatment? ……

Address of doctor ……

4. Has he/she had any physical or mental illness during the past two years?
   YES NO

If yes, from which doctor did he/she receive the treatment?

……

Address of doctor ……

5. EYES

Does he/she wear spectacles? YES NO

If yes, copy the description here if you know it……

BEEHIVE SCHOOL

If no, can he/she see clearly to read from books and classroom board

……

(Please take him/her to an optician if there is any doubt about this)

6. TEETH

Has he/she eat his teeth checked by a dentist recently?.....

If not please do so

7. Can he/she eat normal school food? YES NO

and take part in all normal activities like sports, games, etc. YES NO

8. MEDICINES

Does he/she take any medicine regularly? YES/NO

If so, what for and why?.....

9. What medication are you allowing him/her to bring to school?.....

   a. Any other comment or information you would like us to know?.....

10. In case of any severe illness or emergency, please contact

Name……

Address/Email……

Tele No……

11. State any allergy……