



# Admission Form



For the admission of your child in Oasis fill in the following form :

### Choose your Enrollment Program:

- 1. Full Enrollment
- 2. Partial Enrollment 
  - Twice a week
  - Thrice a week

### Student Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth

Nationality \_\_\_\_\_

Mailing Address \_\_\_\_\_  
\_\_\_\_\_

Mobile No. \_\_\_\_\_ Residence Phone No. \_\_\_\_\_

#### School's Attended (Most recent school first)

S. No.	Name of School	Location	From Class	To Class	Reason for Leaving

### Parent / Guardian's Information

Guardian/Father's Name \_\_\_\_\_

Mailing Address(If Different) \_\_\_\_\_

Phone Number During School Hours \_\_\_\_\_ Evening \_\_\_\_\_

E-mail Address \_\_\_\_\_ CNIC Number \_\_\_\_\_

Occupation \_\_\_\_\_ Designation \_\_\_\_\_ Organization \_\_\_\_\_

Lives with Student Yes  No

Mother's Name \_\_\_\_\_

Mailing Address(If Different) \_\_\_\_\_

Phone Number During School Hours \_\_\_\_\_ Evening \_\_\_\_\_

Mother's E-mail Address \_\_\_\_\_ CNIC Number \_\_\_\_\_

Occupation \_\_\_\_\_ Designation \_\_\_\_\_ Organization \_\_\_\_\_

Lives with Student Yes  No

Guardian's Name \_\_\_\_\_

Mailing Address(If Different) \_\_\_\_\_

Phone Number During School Hours \_\_\_\_\_ Evening \_\_\_\_\_

### Medical Information

1. Has your child ever been Assessed for ASD / Specific Needs Before

Yes  No  If yes, please include Details \_\_\_\_\_

2. Are there any particular medical problems your child may be experiencing which his/her teacher should be aware of ?

● Conditions/diagnosis other than Autism (i.e. Epilepsy (if any):

\_\_\_\_\_

● Allergies

Food  Environmental  Medicines

Is the child using any medications for medical conditions or prescribed by a psychiatrist? (enlist if any)

\_\_\_\_\_

**Please answer the following questions to help us better understand your child:**

3. Does your child have any of the following needs?

● Speech/Communication Preferences (tell us how does the child communicate his/her needs?)

Verbal  Nonverbal

● Sensory Sensitivities (Is your child sensitive to any of these? (check all that apply)

Auditory (sounds)  Visual (lights)  Tactile (touch, nails cutting, hair cutting)

Olfactory (sensitive to smells)  Oral motor (picky eater, mouthing objects)

4. Physical needs (does your child have any physical or mobility needs?) \_\_\_\_\_

● Behavioral needs

Describe any challenging behaviors. \_\_\_\_\_

How do you manage it? \_\_\_\_\_

**Sibling(s) Information**

Name	Age	School Attended

**Emergency Contact**

In case of emergency, please provide names, addresses and phone numbers of contacts if the school cannot contact you.

Name	Relation with child	Address	Phone Number

I hereby declare that the information contained on this form and the information I have provided is correct.

Date \_\_\_\_\_ Parent / Guardian Signature \_\_\_\_\_

**Office Use**

Starting Date \_\_\_\_\_

Enrollment Package:     Full             Partial            (Days and time \_\_\_\_\_)

Fee Decided: \_\_\_\_\_ Compensation \_\_\_\_\_

Transport Charges \_\_\_\_\_

Date \_\_\_\_\_ Admission Approved By \_\_\_\_\_