

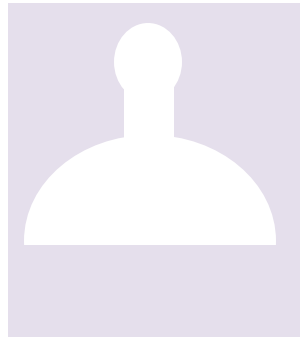


# WEXFORD COLLEGE

First Gate, Oba-Ile Housing Estate, Oba-Ile,  
Akure North Local Government, Ondo State.

Tel: 07068012177, 08159282549,  
08129224898, 09092263065

[www.wexfordcollege.com](http://www.wexfordcollege.com)



## ADMISSION FORM

Term:

Year:

### PARTICULARS OF STUDENT (IN BLOCK LETTERS)

1.	Full Name: <input type="text"/>				
	Surname		Other Names		
2.	Sex: <input type="text"/>	Religion: <input type="text"/>			
3.	Date of Birth: <input type="text"/>				
	Day	Month	Year	Age	
4.	Home Address: <input type="text"/>				
	<input type="text"/>				
5.	Poster Address: <input type="text"/>				
6.	State of Origin: <input type="text"/>			L.G.A.: <input type="text"/>	
7.	Name of Previous School: <input type="text"/>			Last Class: <input type="text"/>	
8.	Address of Previous School: <input type="text"/>				
9.	Class into which Admission is being sought: <input type="text"/>				
10.	Special interest and hobbies: <input type="text"/>				

### PARTICULARS OF PARENT/GUARDIAN/SPONSOR

#### 11. PARENT/GUARDIAN/SPONSOR

FATHER

Name:

Occupation:

Residential Address:

Tel:

E-mail:

Relationship to Student:

Religion:

Date & Signature:

**11. MOTHER**

<b>Name:</b>		<b>Occupation:</b>	
<b>Residential Address:</b>			
<b>Tel:</b>		<b>E-mail:</b>	
<b>Relationship to Student:</b>		<b>Religion:</b>	
<b>Date &amp; Signature:</b>			

**MEDICAL INFORMATION**

a. Does your Child/Ward have Sickle Cell Anaemia?      YES       NO

b. Has your Child/Ward any challenge associated with the following:

Eye       Ear       Nose Bleeding       Asthma

c. Has your Child/Ward been immunized against the following:

1. Measles	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
2. Whooping Cough	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
3. Polio	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
4. Tetanus	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
5. Tuberculosis	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

In case of medical emergency, do you permit us to take your child to the School's Clinic/Doctor?

YES       NO

d. **Family Doctor:**

**Address:**

     **Mobile Phone:**

**GENERAL:**

Any peculiar information about child which you believe would be useful to the school, if confidentiality is required, please see the Principal, otherwise indicate below

## DECLARATION:

I  confirm that the information given above is correct and that I am willing to pay the school fees and obey all School rules and regulations as instructed by the school authority.

Signature

Relationship

## FOR OFFICIAL USE ONLY

Examination/Interview Score:

Remarks (Head Teacher):

Date Admitted:

Deposit Paid

Full Payment:

Balance

## PARTICULARS SUBMITTED

1.  Three current passport photographs:
2.  Record from previous School
3.  Other documents (Birth Certificate, Immunization Record etc):

## ENQUIRY:

Principal: 07038983428

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