

STUDENT INFORMATION

Name			
Family Name	Given Name	Middle Name (If applicable)	Preferred Name
Gender	Date of Birth	Passport	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Day / Month / Year	Passport Country: _____	
Grade Level Applying for	Preferred Start Date	Passport #: _____	
<input type="checkbox"/> PN 1/2 <input type="checkbox"/> PN <input type="checkbox"/> N <input type="checkbox"/> PK <input type="checkbox"/> K <input type="checkbox"/> G1 <input type="checkbox"/> G2 <input type="checkbox"/> G3 <input type="checkbox"/> G4 <input type="checkbox"/> G5 <input type="checkbox"/> G6 <input type="checkbox"/> G7 <input type="checkbox"/> G8 <input type="checkbox"/> G9 <input type="checkbox"/> G10 <input type="checkbox"/> G11 <input type="checkbox"/> G12	Program Applying for	Has your Child been Enrolled at SSIS Previously?	
	<input type="checkbox"/> IB <input type="checkbox"/> German	<input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____	
Expected Length of Stay in China			
Estimated Arrival Date		Estimated Departure Date	
Day / Month / Year		Day / Month / Year	
Siblings			
Name: _____ <input type="checkbox"/> Applying for SSIS <input type="checkbox"/> Attending SSIS Grade: _____			
Name: _____ <input type="checkbox"/> Applying for SSIS <input type="checkbox"/> Attending SSIS Grade: _____			
Name: _____ <input type="checkbox"/> Applying for SSIS <input type="checkbox"/> Attending SSIS Grade: _____			
Name: _____ <input type="checkbox"/> Applying for SSIS <input type="checkbox"/> Attending SSIS Grade: _____			
Address in China			
City/District:		Street # and Name:	
Apartment Name:		Block #/Room #:	
School Bus			
Will you need bus service for your child? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> AM & PM <input type="checkbox"/> Only AM <input type="checkbox"/> Only PM			

PARENT/GUARDIAN INFORMATION

	Parent/Guardian 1	Parent/Guardian 2
Relation to Student:		
Family Name:		
Given Name:		
Passport Country:		
Passport #:		
Email Address:		
Mobile Phone:		
Home Phone:		
China Address:		
Home Country Address:		

PARENT/GUARDIAN COMPANY INFORMATION

Company Name:		
Title:		
Company Address:		
Office Phone:		

EMERGENCY CONTACT

In case of an emergency and both parents cannot be reached please provide local contacts

Family Name:	Given Name:
Mobile Phone:	Home/Office Phone:
Email:	Relationship to Child:

BILLING INFORMATION

Please indicate where the school fee invoice should be sent and provide the correct contact information

<input type="checkbox"/> Parent/Guardian	<input type="checkbox"/> Company
Relationship to Student:	Company Name:
Mailing Address:	Contact Name:
Phone:	Phone:
Email:	Email:

EDUCATIONAL PROFILE

Has your child been tested or been recommended to be tested for any of the following: (Check all that apply)

	Yes	No		Yes	No
ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Autism/Asperger's/Neurodiverse	<input type="checkbox"/>	<input type="checkbox"/>	Language and Speech Needs	<input type="checkbox"/>	<input type="checkbox"/>
Dyslexia	<input type="checkbox"/>	<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Dyspraxia	<input type="checkbox"/>	<input type="checkbox"/>	Physical Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Dysgraphia	<input type="checkbox"/>	<input type="checkbox"/>	Physiotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Dyscalculia	<input type="checkbox"/>	<input type="checkbox"/>	Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Emotional or Behavioral Needs (counselling)	<input type="checkbox"/>	<input type="checkbox"/>	Specific Learning Needs (i.e Reading, Writing, Math)	<input type="checkbox"/>	<input type="checkbox"/>
Gifted or Talented Program	<input type="checkbox"/>	<input type="checkbox"/>	Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Global Delays/Development Delays	<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify) _____				<input type="checkbox"/>	<input type="checkbox"/>

Please explain any of the boxes checked yes above:

Has your child ever had any individualized testing such as psycho-educational tests, intelligence tests, writing, reading or mathematics diagnostics, etc?

Yes No

If yes, please give details:

Has your child ever been given an Individualized Education Plan (IEP) or modified program?

Yes No

If yes, please provide specific details and copies of educational and emotional support documents:

Has your child exhibited behavior problems at home or in a school setting?

Yes No

If yes, please provide specific details:

Has your child ever been suspended or dismissed from any previous schools?

Yes No

If yes, please provide specific details:

Has your child ever skipped a grade or repeated a grade?

Yes No

If yes, please specify grade level(s) and reasons for skipping or repeating:

EDUCATIONAL HISTORY

Name of Current School	
School Address:	Website:
Country:	Dates Attended From: _____ To: _____
Phone Number:	Current Grade Level:
Language Classes are Taught In: (e.g. English, Korean, German)	

Name of Previous School	
School Address:	Website:
Country:	Dates Attended From: _____ To: _____
Phone Number:	Current Grade Level:
Language Classes are Taught In: (e.g. English, Korean, German)	

Name of Previous School	
School Address:	Website:
Country:	Dates Attended From: _____ To: _____
Phone Number:	Current Grade Level:
Language Classes are Taught In: (e.g. English, Korean, German)	

LANGUAGE AND LEARNING PROFILE

Mother to Child:		Between Child and Siblings:	
Father to Child:		Between Parents:	

Please indicate what language your child speaks	Language	Fluency (1 Beginner 2 Intermediate 3 Advanced 4 Fluent)			
First Language (primary):		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Second Language:		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Third Language:		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

Has your child studied English?	Yes	No
If yes, how many years:	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever been enrolled in a full-time English speaking school?	Yes	No
If yes, how many years:	<input type="checkbox"/>	<input type="checkbox"/>
Has your child received EAL/ESL (English as an Additional or Second Language) support in school?	Yes	No
If yes, please provide specific details and indicate the length of time:	<input type="checkbox"/>	<input type="checkbox"/>

Where has your child studied English? (Please check all that apply and indicate length of time)		
<input type="checkbox"/> School ____ months ____ years	<input type="checkbox"/> Language School ____ months ____ years	<input type="checkbox"/> Home ____ months ____ years
<input type="checkbox"/> Private Tutor ____ months ____ years	<input type="checkbox"/> Academy ____ months ____ years	<input type="checkbox"/> Other ____ months ____ years

MEDICAL AND HEALTH HISTORY

Please check if your child has received the following childhood immunizations:

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Rubella	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps
<input type="checkbox"/> Polio	<input type="checkbox"/> Pertussis/Whooping Cough	<input type="checkbox"/> TB	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Typhoid

Has your child received medical referral or treatment for any of the following? (Please check all that apply)

	Yes	No		Yes	No		Yes	No
ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Allergies-Environmental	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Allergies-Food	<input type="checkbox"/>	<input type="checkbox"/>	Dermatological Disease	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Disease	<input type="checkbox"/>	<input type="checkbox"/>
Allergies-Medications	<input type="checkbox"/>	<input type="checkbox"/>	Eye/Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Stomachaches	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

Please list any additional or special medical problems diseases your child has had?

Does your child need corrective help for sight or hearing?

Yes No

If yes, please give details:

Does your child have any physical ailments, which would prevent him or her from participating in physical education classes or other school activities?

Yes No

If yes, please give details:

Does your child have any dietary requirements for religious or medical reasons?

Yes No

If yes, please give details:

Does your child have any specific food or medication allergies?

Yes No

If yes, please list all:

Does your child routinely take medication ?

Yes No

If yes, please specify dosage, reasons for the medication, and how long your child has been taking medication: