

Application No		<b>FOR OFFICE USE ONLY</b>	Transfer Certificate No	
Admission No			Date	D   D   M   M   Y   Y   Y   Y



# GREEN SPROUT INTERNATIONAL SCHOOL

Sai Nagar, Kancharampettai Post, Madurai – 625014  
 Call: 7397393052 & Email: [greensproutinternationalschool@gmail.com](mailto:greensproutinternationalschool@gmail.com)

## ADMISSION APPLICATION FORM – 20 \_\_\_ - 20 \_\_\_

Affix the recent  
passport size  
photo of father

Affix the recent  
passport size  
photo of Mother

Affix the recent  
passport size  
photo of Student

<b>Admission required for</b> (Use Capital Letters only)	
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### ★ INFORMATION OF THE STUDENT (Use Capital Letters only) ★

<b>Name of the Student:</b>								
<b>Gender</b>	Use (✓)	Male		Female		<b>Blood Group</b>		
<b>Date of Birth</b> (In Figures)		D	D	M	M	Y	Y	<b>Nationality</b>
<b>Religion</b>						<b>Caste</b>		
<b>Community</b>	Use (✓)	General	OBC	SC	ST	Others: _____		
<b>Aadhaar Card Number</b>							<b>Age</b>	
<b>Languages Known</b>							<b>Mother Tongue</b>	
<b>Residential Address:</b>				<b>Correspondence Address:</b>				
<b>PIN Code</b>				<b>PIN Code</b>				

### ★ DETAILS OF THE PREVIOUS SCHOOL (If Applicable) ★

<b>Name of the Previous School</b>							
<b>Board Name</b>	Use (✓)	State Board	CBSC	SC	ICSE	Others: _____	
<b>Completed Year</b>		<b>Standard / Grade</b>			<b>Remarks</b>		
<b>Grade / Marks / Percentage obtained in final exams</b>							

### ★ MISCELLANEOUS ★

<b>How did you hear about this school (Please Specify)</b>	
<b>Newspaper / Website / Magazine / Hoardings / Pamphlets / Word of mouth / Catalogue / Referee (Name)</b>	





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## STUDENT MEDICAL HISTORY FORM – 20 \_\_ \_\_ - 20 \_\_ \_\_

Please Tick (✓) in Appropriate Box					
<b>HEARING</b>					
01	Any difficulty observed	YES		NO	
02	Any consultation with doctor done	YES		NO	
	If YES, Explain –				
<b>VISION</b>					
03	Use of spectacles / Corrective Lenses	YES		NO	
04	Any consultation with doctor done	YES		NO	
	If YES, Explain the Power Details -				
<b>GENERAL</b>					
05	Any Meditation taken for general well-being:				
06	Any allergy / Medical Information that school should be aware of:				
07	Personal Marks of Identification (Mandatory):				
	(a) .....				
	.....				
	(b) .....				
	.....				

Date: \_\_ / \_\_ / \_\_\_\_

Signature of Consultant Doctor