



New Day Learning Co., Ltd.

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Enrollment & Child's History

(A separate form should be completed for each child.)

Photograph of child here

Starting Date:

Leaving Date:

Child's Personal Details

First Name		Family Name	
Middle Name		Nickname	
Sex	Male Female	Date of Birth (dd/mm/year)	
Age		Place of Birth	
Nationality		Religion	
Passport Number		Passport issued at	
Date Passport issued		Date Passport expires	
Type of Visa		Date Visa expires	

Residential Address	
Billing Address	

Parent's / Guardians Details

Father

First Name		Family Name	
Middle Name		Nationality	
Passport No.		Type of Visa	
Company		Position/Title	
Office Telephone		Home Telephone	
Mobile Number		Email address	
Home Address			

Mother

First Name		Family Name	
Middle Name		Nationality	
Passport No.		Type of Visa	
Company		Position/Title	
Office Telephone		Home Telephone	
Mobile Number		Email Address	
Home Address			

Guardian

(Must be completed if child is not living with parents)

First Name		Family Name	
Middle Name		Nationality	
Passport No.		Type of Visa	
Company		Position/Title	
Office Telephone		Home Telephone	
Mobile Number		Email address	
Home Address			

Nanny / Driver Details

Nanny's Name		Nanny's phone number	
Driver's Name		Driver's phone number	

IN CASE OF EMERGENCY

Who should we contact in case of an emergency if we cannot get hold of either parent? _____

Relationship to child / family _____

Contact telephone number _____

In case of an emergency, we will use **Kluaynamthai** Hospital.

Education History

Details of Previous Schooling

Name of School	Country	Was This An International School?		From	To	Year/Grade Level
		Yes	No	Month/Year	Month/Year	

Education History

Assessments

Please attach all available reports to this enrollment

Has your child had any of the following assessments or been seen by any of the specialists listed below:

Assessment/Test/Letter	Report Available		Date of Assessment/Test/Letter
	No	Yes	
Vision			
Hearing			
Speech / Language			
Occupational Therapist			
Counselor/ Psychologist			
Educational Psychologist			
Pediatrician			
Psychiatrist			
Other Specialist Doctor			
Other Health Personnel			
SEN Support			
Other			

Education History

Medical History				
Diagnosis or Medical Certificate				
			Yes	No
Autism Spectrum Disorder				
Down Syndrome				
Learning Difficulty (LD)				
Cerebral Palsy				
Cleft Lip/Palate				
Physical Disability				
Visual Impairment				
Speech Delays				
Family History of Speech Difficulties				
Attention Deficit Disorder or ADHD				
Significant emotional or behavioral problems (ex: depression, anxiety, or etc.) Please specify: _____				
My child did not meet their milestones, but has no diagnosis				
Child's Language Ability				
Is English the child's 1st Language?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If the answer is No, please complete the table below	
	Very Good	Good	Fair	A Little
Listening				
Speaking				
Reading				
Writing				
Which language is spoken within the family?			Does the child understand any other language(s)?	
Are there any other factors not covered above which you think may have influenced your child's development or learning progress? (Please explain)				

Medical Information (continued)

Primary Physician Name

Hospital at which you see your Primary Physician

Contact Details

Allergies

Does your child have any allergies? If yes, please specify

Does your child take any medication for allergies? Please list below

If your child has an allergic reaction, what course of action should be taken?

Medication

My child currently takes medication for (indicate reason, medicine & dosage):

1.

2.

3.

4.

Medical Background (additional information)

Was your child born premature? (If yes, how many weeks?)

Was it a normal birth?

Did your child need special care after birth? (Please provide details)

At what age did your child start to walk unaided (first steps)?

At what age did your child speak his/her first word/ words?

At what age did your child begin to put words together (2 or more words?)

Has your child been hospitalized for a serious condition?

Why and when did hospitalization occur?

Any brain injury or suspected brain injury

Any ongoing medical conditions?

Parental Questionnaire

To the best of your ability and in your opinion please answer the questions below

Main concerns that you have for your child are:

Outline your child's strengths:

Please answer the questions below using the following ratings:

Not at all = 0

Seldom = 1

Sometimes = 2

Usually = 3

Almost always = 4

	Rating
Cooperates around the home	
Able to follow instructions	
Able to cope with changes in routine	
Completes homework with minimal assistance	
Has temper outbursts	
Gets on well with siblings	
Is easily distracted	
Forms good friendships	
Appears to feel good about self	
Able to organize self (e.g. prepares books, pencils, packs school bag)	
Worries about things	

Parental Questionnaire

Behavior

If your child has specific behavioral difficulties, please give details of typical behaviors below, and of any effective tactics you use to calm your child: (This information is very useful to help us support your child's initial settling in period). If your child has a previous behavioral support plan please attach it with this document.

Please add any additional information or comment below:

I have answered the above questions to the best of my ability. I have also attached all needed documents to this enrollment form.

Signed _____

Date _____

Name _____