

ISAIAH THOMAS SECONDARY SCHOOL  
ST. JOSEPH  
COMMONWEALTH OF DOMINICA  
TEL: 7674496386

<b>FOR OFFICE USE ONLY</b>	
CEP/JSP	_____
CODE	_____
FORM	_____

APPLICATION FOR ENTRY  
PART 1- GENERAL INFORMATION

(PLEASE PRINT)

1. NAME OF APPLICANT: \_\_\_\_\_
2. PLACE OF BIRTH: \_\_\_\_\_
3. DATE OF BIRTH: \_\_\_\_\_
4. SEX: (    ) MALE    (    ) FEMALE
5. PREVIOUS SCHOOL: \_\_\_\_\_
6. PERIOD OF ATTENDANCE: \_\_\_\_\_
7. RELIGION: \_\_\_\_\_
8. NUMBER OF BROTHERS AND SISTERS AT HOME: \_\_\_\_\_
9. POSITION IN FAMILY (E.g. 3 OF 5) \_\_\_\_\_
10. LIST ALL YOUR BROTHERS AND SISTERS AT THE ISAIAH

THOMAS SECONDARY SCHOOL.

NAME	FORM	NAME	FORM

11. FATHER'S NAME: \_\_\_\_\_

ADDRESS \_\_\_\_\_

OCCUPATION \_\_\_\_\_ TEL: \_\_\_\_\_

12. MOTHER'S NAME: \_\_\_\_\_

ADDRESS \_\_\_\_\_

OCCUPATION \_\_\_\_\_ TEL: \_\_\_\_\_

13. GUARDIANS'S NAME: \_\_\_\_\_

ADDRESS \_\_\_\_\_

OCCUPATION \_\_\_\_\_ TEL: \_\_\_\_\_

RELATIONSHIP TO STUDENT: \_\_\_\_\_

#### PART 2: HEALTH

1. DOCTOR'S NAME: \_\_\_\_\_

2. OUTSTANDING DEFECTS(PLEASE TICK APPROPRIATE BOX IF YOU HAVE DUFFICULTY WITH ANY.)

(  ) HEARING (  ) EYE (  ) BLADDER (  ) OTHER

3. SERIOUS ILLNESS: \_\_\_\_\_

4. SPECIAL MEDICATION: \_\_\_\_\_