

# APPLICATION



## CHECKLIST

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1. 입학원서
2. 재학증명서 (영문)
3. 성적증명서 (영문)
4. 주민등록등본
5. 사진 3매 (여권용)



# Saint Paul Academy, Daechi

## 세인트폴 대치 아카데미

<b>Student Name</b>					Photo 3 X 4 cm	
	Family Name / First Name					
<b>Date of Birth</b>	/ /			<b>Gender</b>		
	Month	Day	Year	<b>Nationality</b>		
<b>Address</b>						
<b>Applying Grade</b>						
<b>Cell Phone</b>			<b>Email Address</b>			

<b>Educational Background</b>	Elementary School	
	Middle School	
	High School	
	Current Grade	

<b>Mother</b>		<b>Father</b>	
Name		Name	
Cell Phone		Cell Phone	
Email Address		Email Address	
Occupation		Occupation	
Home Phone		Home Phone	

<b>Siblings</b>					
Name	School Attending	Grade	Gender	Date of Birth	Citizenship

# MEDICAL INFORMATION AND INOCULATION RECORD

Student Name \_\_\_\_\_ Date of Exam \_\_\_\_\_

Family Name / First / Middle

## PART I - MEDICAL HISTORY

Has the applicant ever had a history of any of the following:

<i>Yes No</i>	<i>Yes No</i>	<i>Yes No</i>	<i>Yes No</i>
<input type="checkbox"/> Allergies	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Measles	<input type="checkbox"/> Polio
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Enuresis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Appendix removal	<input type="checkbox"/> Headache	<input type="checkbox"/> Menstrual disorder	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Parasites	<input type="checkbox"/> Sleep disorder
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tonsils Removal
<input type="checkbox"/> Cough (persistent)	<input type="checkbox"/> Hernia	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Malaria	<input type="checkbox"/> Rubella; Year: _____	<input type="checkbox"/> Vertigo

Any disease, impairment or abnormality of:

<i>Yes No</i>	<i>Yes No</i>	<i>Yes No</i>	<i>Yes No</i>
<input type="checkbox"/> Digestive system	<input type="checkbox"/> Ears, Hearing	<input type="checkbox"/> Locomotor system	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Bones, joints	<input type="checkbox"/> Genito-Urinary	<input type="checkbox"/> Lungs	<input type="checkbox"/> Tonsils, throat nose
<input type="checkbox"/> Brain, Nervous System	<input type="checkbox"/> Heart, Blood vessels	<input type="checkbox"/> Menstrual cycle	<input type="checkbox"/> Immune System
<input type="checkbox"/> Blood, Endocrine System		<input type="checkbox"/> Skin (acne, etc.)	

Has the applicant had any of the following:

<i>Yes No</i>	<i>Yes No</i>	<i>Yes No</i>
<input type="checkbox"/> restriction of a physical Or activity during the past five years	<input type="checkbox"/> treatment or counseling for a nervous condition, character personality, disorder or emotional problems	<input type="checkbox"/> difficulty with school studies teacher

Please give a detailed explanation of any of the items above marked "yes." \_\_\_\_\_

Has the applicant ever been hospitalized: Yes No If "yes," please give the date and diagnosis of each illness or accident.

Is the applicant taking any medication at this time? Yes No If "yes," please list medication(s) and reason(s). \_\_\_\_\_

# MEDICAL INFORMATION AND INOCULATION RECORD

(continued)

## PART II - PHYSICAL EXAMINATION

Height \_\_\_\_\_ (m) Weight \_\_\_\_\_ (kg) Blood Pressure \_\_\_\_\_

Does the student wear contact lenses? Yes No Does the student wear glasses? Yes No

Applicant's uncorrected vision: R \_\_\_\_ / \_\_\_\_ L \_\_\_\_ / \_\_\_\_ With correction: R \_\_\_\_ / \_\_\_\_ L \_\_\_\_ / \_\_\_\_

Hearing: R \_\_\_\_ / \_\_\_\_ L \_\_\_\_ / \_\_\_\_ With correction: R \_\_\_\_ / \_\_\_\_ L \_\_\_\_ / \_\_\_\_

Are there any current abnormalities of the following systems? If "yes" provide additional information.

<i>Yes No</i>	<i>Yes No</i>	<i>Yes No</i>
<input type="checkbox"/> Cardiovascular system	<input type="checkbox"/> Menstrual Cycle	<input type="checkbox"/> Respiratory System
<input type="checkbox"/> Ears, Nose, Throat	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Skin (acne, etc.)
<input type="checkbox"/> Eyes	<input type="checkbox"/> Metabolic/Endocrine	<input type="checkbox"/> Teeth and Gums
<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Neuropsychiatric	<input type="checkbox"/> Other _____
<input type="checkbox"/> Genito-Urinary System	<input type="checkbox"/> Pelvic	

Is the student now under treatment for any medical or emotional conditions? Yes No

If "yes," please explain:

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Does the student have an eating disorder or a history of eating disorder? Yes No

If "yes," please explain:

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Recommendation for physical activity: Unlimited Limited (please explain)

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Your opinion on the student's state of health: Excellent Good Fair Poor

Guardian/Parent' Full Name \_\_\_\_\_

Guardian/Parent' Signature \_\_\_\_\_ Date \_\_\_\_\_

# Saint Paul Academy, Daechi

## 세인트폴 대치 아카데미

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Saint Paul American School System 산하의 한국에 위치한  
Saint Paul American Schools 의 Daechi Campus 입니다.

1. 위 치: 서울시 강남구 역삼로 427
  2. 형 태: 통학
  3. 운 영: Saint Paul American School System in US
  4. 대 상: 중3-고2에 해당하는 학생
  5. 입학심사
    - 1) 지원서와 3년간 성적표 제출
    - 2) Placement test (영어/수학)
- \* 필요시 인터뷰 진행.

# Scholarship

## 1. 신입생 장학금

### 1) 영어장학금 (첫해)

토플 (IBT) 100점 이상 (9학년) - 백만원 \*1), 2) 중복수혜불가

### 2) 형제장학금 (매년)

형제(각 5%), 3형제(각 7.5%)

## 2. 재학생 장학금

수석-2백만원, 차석-백만원



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