APPLICATION

Saint Paul Daechi Academy

Tel: +82-2-568-3345

910 Daechi-dong Gangnam-gu,
Seoul, 06200 Korea

www.stpaulacademy.org

Saint Paul Daechi Academy

Student Name					Photo 3 X 4 cm
	Family Name / First Name				
Date of Birth	/ /		**Gender**		
	Month / Day / Year		**Nationality**		
Address					
Cell Phone		**Email Address**			

Educational Background	Elementary School	
	Middle School	
	High School	
	Current rade	

Mother		**Father**	
Name		Name	
Cell Phone		Cell Phone	
Email Address		Email Address	
Occupation		Occupation	
Home Phone		Home Phone	

Siblings

Name	School Attending	Grade	Gender	Date of Birth	Citizenship

CHECKLIST

□ 1) Application
□ 3) Transcript
□ 3) Certificate of Attendance
□ 4) 3 Photographs (Size: 3 x 4 cm)

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:

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

Any disease, impairment or abnormality of:

Yes No	*Yes No*	*Yes No*	*Yes No*
□□ Digestive system	□□ Ears, Hearing	□□ Locomotor system	□□ Varicose veins
□□ Bones, joints	□□ Genito-Urinary	□□ Lungs	□□ Tonsils, throat nose
□□ Brain, Nervous System	□□ Heart, Blood vessels	□□ Menstrual cycle	□□ Immune System
□□ Blood, Endocrine System		□□ Skin (acne, etc.)	

Has the applicant had any of the following:

Yes No	*Yes No*	*Yes No*
□□ restriction of a physical Or activity during the past five years	□□ reatment or counseling for a nervous condition, character personality, disorder or emotional problems	□□ 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.

Yes No	*Yes No*	*Yes No*
□□ Cardiovascular system	□□ Menstrual Cycle	□□ Respiratory System
□□ Ears, Nose, Throat	□□ Musculoskeletal	□□ Skin (acne, etc.)
□□ Eyes	□□ Metabolic/Endocrine	□□ Teeth and Gums
□□ Gastrointestinal	□□ Neuropsychiatric	□□ Other_____
□□ Genito-Urinary System	□□ Pelvic	

Is the student now under treatment for any medical or emotional conditions? Yes No
If ″yes,″ please explain:

_____

_____

Does the student have an eating disorder or a history of eating disorder? Yes No
If ″yes,″ please explain:

_____

_____

Recommendation for physical activity: Unlimited Limited (please explain)

_____

_____

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

Guardian/Parent′ Full Name_____

Guardian/Parent′ Signature _____ Date _____