

SCHOOL OF NURSING

INSTITUTE OF PARA-MEDICAL TECHNOLOGY

D, 5 PAHARI CHHATTARPUR, NEW DELHI-110074

APPLICATION FORM FOR ADMISSION

Student Information

Form No.

Name of the Candidate

Gender M F Course Applying for 2022-23 Academic Year

Date of Birth

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 Place of Birth Nationality

Opted (2022-23) Yes No Blood Group Religion

School Bus Required Yes No Mother Tongue

Applicant's Prior Schools

Educational Qualification :

Qualification	Board/University	Year of Passing	% of Marks	Subjects Taken
Matric/10th				
10+2				

Medium of Instruction

Address for Correspondence (With Pin code)

Mobile No. (Candidate)..... Mobile No. (Father/Mother).....

Email (Candidate) Email (Father/Mother)

Aadhar No. Income (Father/Mother)

Parent's resource

Ways in which you would like to volunteer in the school (e.g. Field Trip Assistance, Library Reading Program, Guest Speaker etc.)

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Details of siblings (List from eldest to youngest)

Name	M/F	Date of Birth	Grade	Education	Address

Reference

Name	Address	Occupation

Student's Strengths & Interests (

Please check the appropriate answer

Yes No

Has your child ever been in a speech therapy program?

Has your child ever been identified as having a learning disability?

Has your child ever experienced social, emotional or behavioral difficulties?

If yes, please describe.....

Does your child have any illness/disease, allergies or physical disabilities that require special attention?

If yes, please describe.....

I/We hereby apply for admission of the above named student to School of Nursing, I.P.M.T., Chatterpur, New Delhi-74 and certify that the information furnished by me/us is complete and correct to the best of my/our knowledge. I/We authorise School of Nursing, I.P.M.T. to contact past and current schools, teachers, tutors, administrators and other sources to obtain information to support this application. All materials submitted in support of this application becomes the property of School of Nursing, I.P.M.T. are confidential and will not be released. I/We agree that my/our child/ward and I/we will abide by all the rules and regulations of the school. I/We understand that should my/our child/ward require special educational assistance there will be an extra cost for these as indicated in the fee structure. I/We give permission for my/our child/ward to go on organised school trips and to participate in regular physical education and co-curricular activities. We jointly undertake that all risk at the clinical postings infection/post-infection shall be our responsibility and risk, In No way the parent hospital/ School of Nursing shall be held responsible. The undersigned Parent/Guardian also understands that a positive and constructive working relationship between the school and the student's parents (or guardian) is essential to the fulfillment of the school's mission.

Signature of Parent/Guardian

Signature of Candidate.....

Relationship with the student

Date

Encl: All documents to be Self Attested

1. Photocopy of Matric /10+2
2. Photocopy of Additional Qualification Documents
3. Character Certificate from Previous School (Last Attended)
4. Medical Fitness Certificate from a qualified Medical Professional (Not below MBBS)
5. Migration Certificate from Last School /board attended
6. Photocopy of Aadhar Card of Candidate
7. 10 Colored Passport Size Photograph

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Student ID

HEALTH FORM

Student Name

Emergency Contact

Mother's / Guardian's Name

Mobile No.

Email ID

Father's / Guardian's Name

Mobile No.

Email ID

Name & Grade of Sibling(s)

Blood Group of the Student

MEDICATION PERMISSION

I / We give my consent to the School Doctor/ Nurse to administer medication/first-aid for common ailments/medical situations. I /We am/are conscious of the fact that medication may in rare cases produce unwanted side effects.

EMERGENCY PERMISSION

I/We give my/our consent for emergency measures to be taken in case of an emergency situation arising due to an accident/violent injury/medical or surgical emergency with the understanding that I (the mother/the father/the guardian of the student) shall be notified/informed as soon as possible. The school will accept no responsibility for any unforeseen incident that may occur due to the administration of medicine/treatment in both emergency and non-emergency situations, though necessary precautions will be taken.

Mother's (Guardian)Signature

Father's (Guardian)Signature

Date.....

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STUDENT'S HEALTH HISTORY FORM
(TO BE FILLED IN BY THE PARENTS)

Did your child have any of the following ailments in the past/present:

1. Ophthalmic (eye related) problem/s
2. Dental problem/s
3. Orthopaedic problem/s
4. Respiratory problem/s (e.g. Asthma)
5. Skin problem/s
6. Allergy/Allergies
7. Epilepsy
8. Any allergy to specific medicine
9. Pediatric diabetes
10. Any other ailment not mentioned above

Is your child under any medication, if yes please specify the medication and the purpose

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Note: If a child suffers from rheumatic heart disease / bronchial asthma / epilepsy / endocrine disorder /allergy to food, medicines etc. / has an illness which requires long term medication, please furnish details of the illness giving frequency, severity of disease etc. and photocopy of the health records and treatment being administered.

Mother's (Guardian)Signature

Father's (Guardian)Signature

Date.....