

APPLICATION FORM

(mm / yr)

AUTISM PARTNERSHIP PRIMARY SCHOOL



UG2, UG/F, Provident Centre, 21-53, Wharf Road North Point, Hong Kong
Tel: 2526 3061 Fax: 2982 4403

STUDENT'S NAME: (BLOCK LETTERS)

(Family / First / Middle)

PLEASE ENCLOSE THE FOLLOWING DOCUMENTS WHEN MAKING AN APPLICATION

- A copy of school reports OR psychological reports and assessment for the past two years.
- A copy of birth certificate.
- A copy of student's passport pages showing student's photograph ID.
- A copy of student's HKID card OR HK Visa approval stamps in passport (if not currently available, essential before student's first day of school)
- Two recent passport photographs.
- A non-refundable application fee of HK\$1,500.

Please make all cheques payable to: Autism Partnership Foundation Limited.

Application fees are non-refundable and are only valid for the academic year for which the applicant is applying.

OFFICE USE

Chq No.:

Receipt No.:

CHILD INFORMATION

English Name: (Family / First / Middle)

Chinese Name:

Sex:

Date of Birth:

HKID No.:

Passport No.*:

* **ONLY IF THE CHILD DOES NOT CURRENTLY HAVE A HKID**

- 1. CHILD'S PASSPORT HAS TO BE VALIDATED.**
- 2. PLEASE PROVIDE PHOTOCOPIES OF PAGES SHOWING PHOTOGRAPH ID AND VISA APPROVAL STAMPS.**

Home Address:

Phone No.:

Fax No.:

Language spoken at home:

Preferred language for tuition:

PARENT INFORMATION (FATHER / GUARDIAN)

English Name: (Family / First / Middle)

Chinese Name:

Occupation:

Employer:

HKID No.:

Phone No.:
Business Hours

Mobile No.:

Email Address:

PARENT INFORMATION (MOTHER / GUARDIAN)

English Name: (Family / First / Middle)

Chinese Name:

Occupation:

Employer:

HKID No.:

Phone No.:
Business Hours

Mobile No.:

Email Address:

EMERGENCY CONTACT

Name:

Relationship to child:

Contact No.:

PICK UP & DROP OFF DETAILS

1. Name of person responsible:

Mobile No.:

2. Name of person responsible:

Mobile No.:

CORRESPONDENCE / BILLING INFORMATION

Correspondence address:

HK home address (details provided on reverse)

Other

Preferred method of contact:

Mail

Fax

Email

Name of person responsible for payment:

Tel:

Note that a complete application form with accurate information is required for consideration or continuation of enrolment. Incorrect or withheld information may affect application or enrolment.

Signature of Parent / Guardian:

Date:

VIDEO CONSENT FORM

I hereby give consent for my son / daughter

to be video taped for the purposes of evaluation, assessment and training.

Signature of Parent / Guardian:

Date:

MEDICAL CONDITIONS (ALLERGIES / MEDICATION)