



# West Nairobi School

P.O. Box 1333 - 00502  
Nairobi, Kenya

Tel.: 254 709 331 000, 254 733 610 394, 254 703 610 394  
[www.westnairobischool.org](http://www.westnairobischool.org)    [info@westnairobischool.org](mailto:info@westnairobischool.org)



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Thank you for choosing West Nairobi School as your school of choice

## **Instructions:**

- The application fee is 185 US Dollars (non-refundable)
- Complete all pages
- The health assessment form must be completed by your physician
- Submit all the completed forms to admissions

If you have any questions, please contact the admissions director at  
[admissions@westnairobischool.org](mailto:admissions@westnairobischool.org) Or call 0709 331 000, 0733 610 394, 0703 610 394.



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updated November 2023

## APPLICATION FOR ADMISSION

Non-Refundable Application Fee: 185 U.S. Dollars

Please fill this form completely.



Pupil's Name: \_\_\_\_\_  
Last First Middle Name

\_\_\_\_\_  
Name Used

Grade and Date of Requested Entrance: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Bus Transport Needed? Yes No  
Grade Date (dd/mm/yy)

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex: \_\_\_\_\_ Birthplace: \_\_\_\_\_  
Day Month Year City Country

Citizenship: \_\_\_\_\_ Passport Number: \_\_\_\_\_

Issue Date: \_\_\_\_\_ Expiry Date: \_\_\_\_\_ (Please provide photocopy of passport)

Authority to be in Kenya Dependent Pass / Pupil Pass / Other (please list) \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
P.O. Box or Street Name and Number City Country

First Language Spoken: \_\_\_\_\_ Language(s) Spoken at Home: \_\_\_\_\_

### Father's Information

Father's Name: \_\_\_\_\_  
Last First Mobile Phone #

Father's Email Address: \_\_\_\_\_

Citizenship: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employers Address: \_\_\_\_\_  
P.O. Box or Street Name and Number City Country

Mother's Information

Mother's Name: \_\_\_\_\_  
*Last First Mobile Phone #*

Mother's Email Address: \_\_\_\_\_

Citizenship: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employers Address: \_\_\_\_\_  
*P.O. Box or Street Name and Number City Country*

Guardian's Information (IF not living with mother or father)

Guardian's Name: \_\_\_\_\_  
*P.O. Box or Street Name and Number City Country*

Guardian's Email Address: \_\_\_\_\_

**Siblings Already Attending WNS**

<u>Name</u>	<u>Grade</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

**PREVIOUS TWO YEARS OF SCHOOLING**

NAME OF SCHOOL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Grade(s): \_\_\_\_\_ Dates: \_\_\_\_\_

NAME OF SCHOOL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Grade(s): \_\_\_\_\_ Dates: \_\_\_\_\_

The Following Questions Do Not Necessarily Affect Enrolment

Has the applicant ever been suspended or expelled from school?	Yes	No
Has the applicant had any emotional, behavioural, and or learning difficulties?	Yes	No
Has the applicant benefited from ESL/ELL in the past?	Yes	No
Ever had an IEP (Individualized Education Program), a 504 Plan, or similar?	Yes	No
Ever been diagnosed as having ADD, ADHD, Autism, or similar?	Yes	No
Any serious/chronic medical conditions the school should be aware of?	Yes	No

If the answer is “yes” to any question, please explain and supply all diagnostic results, etc.

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(Please note that WNS is able to admit children with minor learning difficulties, but does not have a program nor personnel to care for children with serious learning difficulties.)

**REFERENCES and EMERGENCY CONTACTS (Other than Parents & within Nairobi when possible):**

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Mobile #: \_\_\_\_\_
2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Mobile #: \_\_\_\_\_

**\*\*\*Please mark an X in one of the boxes to give consent for WNS to use your child’s photo for promotional materials.  
[ ] YES-I give permission to use my child’s photo [ ] NO-I do not give permission for WNS to use their photo**

**PLEASE NOTE:**

Pupils are subject to discipline as may be necessary as defined in the Parent and Student Handbook. Parents shall read and sign the acknowledgement form in the Parent and Student Handbook. The use or possession of tobacco, illegal substances and / or alcoholic beverages is strictly forbidden.

All communications should be addressed to: West Nairobi School, P.O. Box 1333, Nairobi Karen 00502, Kenya or [admissions@westnairobischool.org](mailto:admissions@westnairobischool.org)

**IMPORTANT PAYMENT INFORMATION**

Person or Organization responsible for payment: \_\_\_\_\_

Contact name and contact number: \_\_\_\_\_

Contact email address: \_\_\_\_\_

Parents' Religious Affiliation: \_\_\_\_\_

*(This information for statistical purposes only. WNS does not discriminate on basis of religion, national origin, or sex of a student.)*

How or from whom did you hear about WNS?  Online (Website, Facebook, or Other Sites) \_\_\_\_\_

Expo  Word of Mouth  EA Private Schools Guide  Other: \_\_\_\_\_

**SPECIAL NOTE:**

Once a student is accepted to West Nairobi School a deposit shall be paid to reserve the students place. These deposits are non-refundable but will be fully applied towards tuition.

I hereby certify that the above particulars are correct. I am aware that the West Nairobi School follows the American course of studies. I permit my child full participation in all activities including religious instruction, which West Nairobi School includes in its curriculum. I expressly agree to allow West Nairobi School to contact my references and former schools. I understand my student may not be accepted and enrolled in West Nairobi School.

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date



**West Nairobi School Student Health Assessment**  
*No admissions will be processed without the completion of this form*

**Part 1: Student Health Assessment (to be completed by Parent/Guardian)**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last Name First Name Middle Name (Day/month/year)

**Part 2: Health Evaluation (to be completed by your Physician)**

Health Examination Date: \_\_\_\_\_ (evaluation must be done after child is 3 years of age for Pre-K)

Blood Type \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

**For Pre-K students:** Eyes \_\_\_\_\_ Vision R 20/ \_\_\_\_\_ L/20 \_\_\_\_\_ with or without corrective device (circle one)

Ears \_\_\_\_\_ Hearing R \_\_\_\_\_ L \_\_\_\_\_

**Is there any evidence for concern in the areas listed below? Please check the results of your examination.**

Allergies (Drugs, Food, Insects) Yes  If "Yes" please indicate what and reaction suffered:  
\_\_\_\_\_

Vision	Yes <input type="checkbox"/>	Hearing	Yes <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	Speech	Yes <input type="checkbox"/>
Behavior/Emotional	Yes <input type="checkbox"/>	Development	Yes <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	ADD/ADHD	Yes <input type="checkbox"/>
Seizures	Yes <input type="checkbox"/>	Bladder	Yes <input type="checkbox"/>
Birth Defects	Yes <input type="checkbox"/>	Bowel	Yes <input type="checkbox"/>
Cerebral Palsy	Yes <input type="checkbox"/>	Activity Limits	Yes <input type="checkbox"/>
Heart	Yes <input type="checkbox"/>		

**No concerns in the areas listed above**

**Part 3: Immunization History**

*Vaccination is a proven tool for controlling and even eradicating infectious diseases. It is an easier and less risky way to become immune. It protects not just the individual but an entire community.*

**Compulsory Vaccines (Please indicate dates given, or attach a copy of the records)**

BCG or PPD (Tine Test) \_\_\_\_\_

Diphtheria/Pertussis/Tetanus (DTP): No. 1 \_\_\_\_\_ No. 2 \_\_\_\_\_ No. 3 \_\_\_\_\_

No. 4 \_\_\_\_\_ No. 5 \_\_\_\_\_ No. 6 \_\_\_\_\_

Polio (OPV or IPV): No. 1 \_\_\_\_\_ No. 2 \_\_\_\_\_ No. 3 \_\_\_\_\_ No. 4 \_\_\_\_\_ No. 5 \_\_\_\_\_

Measles, Mumps, Rubella (MMR): No. 1 \_\_\_\_\_ No. 2 \_\_\_\_\_

Yellow Fever: \_\_\_\_\_

**Recommended Vaccines:**

Hepatitis B: No. 1 \_\_\_\_\_ No. 2 \_\_\_\_\_ No. 3 \_\_\_\_\_

Hepatitis A: No. 1 \_\_\_\_\_ No. 2 \_\_\_\_\_

Hib: No. 1 \_\_\_\_\_ No. 2 \_\_\_\_\_ No. 3 \_\_\_\_\_ No. 4 \_\_\_\_\_

Tetanus Booster: \_\_\_\_\_

Varicella: \_\_\_\_\_ (If child has not had Chicken Pox before starting school)

**Part 4: Additional Information from Medical Practitioner**

The above mentioned student has had a complete history and physical examination, and is free of infection or contagious diseases and can participate in normal school activity? Yes  No

If no, please state condition or limitations.

\_\_\_\_\_  
\_\_\_\_\_

Name of Medical Examiner: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address of Medical examiner: \_\_\_\_\_

Email of Medical Examiner: \_\_\_\_\_

\_\_\_\_\_

Signature and Stamp of Medical Examiner

\_\_\_\_\_

Date

**Part 5: Medications**

**Please check if you grant permission to West Nairobi School to administer the following non-prescription medications to your child.**

Antacid Tablet  Throat Lozenges  Ear Drops  Eye Drops  Panadol (Paracetamol/Tylenol)

Ibuprofen  Piriton (antihistamine)

Is your child taking any medication regularly at home? Yes  No

If yes, Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Purpose \_\_\_\_\_

**Additional Parent comments to the School Health Officer:**

\_\_\_\_\_

\_\_\_\_\_

**In case of medical emergency, please note that your child will be transported to Karen Hospital, located on Lang’ata Road in Karen.**

In the event of “NO WARNING” civil disorder during the school day prohibiting safe travel, I grant West Nairobi School authority to assume custody of my child, without liability to West Nairobi School.

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_