



CHEVALIER SCHOOL , INC.

McArthur Hi-way, Sto. Domingo, Angeles City

Telephone Nos.: 045626-0569, 09691989477
09674064534

Website: www.chevalierschool.edu.ph

JUNIOR HIGH SCHOOL RECOMMENDATION FORM

Applicant's Name: _____
Last First Middle

School currently enrolled in: _____

Address of the School _____

Grade level applying for: (kindly check) Grade 7 Grade 8 Grade 9 Grade 10

The student whose name appears above is applying for admission to Chevalier School, Inc. We request this recommendation form to be completed by the **CLASS ADVISER**. All information, reports and recommendation about the applicant are kept confidential.

1. In relation to other students in the applicant's age group, please check (✓) the appropriate box for each item below.

	Excellent	Good	Fair	Poor
Academic Performance				
Attendance				
Sense of responsibility				
Self – discipline				
Interpersonal Skills				
Leadership Ability				
Communication Skills				
Study Habits				
General Conduct				

The applicant's scholastic average is _____ as of _____, 20____.
Month Year

2. Please specify any behavioral concerns about the applicant that may need teacher's attention:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Restless | <input type="checkbox"/> Talkative | <input type="checkbox"/> Bully |
| <input type="checkbox"/> Moves a lot | <input type="checkbox"/> Inattentive | <input type="checkbox"/> Dishonest |
| <input type="checkbox"/> Lack of or no eye contact | <input type="checkbox"/> Disrespectful | <input type="checkbox"/> Manipulative |
| <input type="checkbox"/> Poor social skills | <input type="checkbox"/> Aggressive | |
| <input type="checkbox"/> Others: (specify) _____ | | |

Please specify any particular strength and/or difficulties the student has.

3. Health / Physiological Conditions

Please check the condition/s that applies / apply to the applicant that should be taken into consideration:

- | | | | | |
|-------------------------------------|---|---------------------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Visual Impairment | <input type="checkbox"/> Surgery | <input type="checkbox"/> Allergies | <input type="checkbox"/> None |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Speech Delay | <input type="checkbox"/> Others _____ | |

Is the student fit to attend a traditional classroom setting?

- Yes No

How long have you known the applicant? _____ In what capacity? _____

Recommendation:

- Strongly Recommended
 Recommended
 Recommended with reservation (state reason) _____
 Not Recommended

Name and Signature of Recommender: _____ Date: _____
Designation: _____
School affiliated: _____ Contact Number: _____

Note: Please return to the applicant in a sealed envelope with your signature across the flap. Thank you for your time.