



Date	Starting Date Required	
Child's Details		
Child's name & Surname		
Date of Birth		
Gender		Language
Nationality		Religion
Physical Address		
Postal Address		
Name of previous school		

Background Details	
Does your child have any of the following:	
Vision problems Please explain	
Hearing problems Please explain	
Speech problems Please explain	
Do you have any concerns about any aspect of your child's development? Please attach all developmental reports.	
Does your child have any health problems we should be aware of? Please explain	
Has your child had any serious accidents or operations? (Explain)	
List other illnesses your child has had	
Does your child have any allergies? If so, please describe	
Is anyone in the family allergic to bees?	
Has your child ever been stung?	Reaction?
Does your child take any regular medicine?	
Are there any foods / drinks your child should not have, and reasons why?	
Any other concerns   Habits   Emotional   Physical Needs   Fears	

**Please sign below:**

**Date:**

Mother:

Father:

Guardian:

**Attach copy of forms please:**

Mothers ID		Account Structure	
Fathers ID		Clinic Card	
Child Birth Certificate		Immunization Form	
Indemnity Form		Medical Aid Card	

<b>Starting date</b>	
<b>Class Allocation</b>	