



Enrolment Form

Registration Date

Start Date

Full Day / Half Day

Parent/Guardian Information

Mother/Guardian First Name: _____ Last Name: _____

Identity Number: _____

Address: _____

Occupation: _____ Home Phone: () _____

Employed By: _____ Office Phone: () _____

Work Address: _____ Cell Phone: () _____

Email: _____

Marital Status: Married Single Divorced Separated Widowed

Home Language: _____

Father/Guardian First Name: _____ Last Name: _____

Identity Number: _____

Address: _____

Occupation: _____ Home Phone: () _____

Employed By: _____ Office Phone: () _____

Work Address: _____ Cell Phone: () _____

Email: _____

Marital Status: Married Single Divorced Separated Widowed

Home Language: _____



Child Information

First Name: _____ Last Name: _____

Name child prefers to be called: _____

Age: _____

Child's Address: _____

Gender: Male Female Date of Birth: _____

Religion: _____

List any existing medical conditions, medication and/or special attention your child may require?

Allergies: _____

Are your Child's Vaccinations / Immunizations up to date? Yes No

Pediatrician's Name: _____ Phone: () _____

Address: _____

Medical Aid Details

Main Member: _____

Medical Scheme: _____

Medical Aid Number: _____



Emergency Contacts & Authorized Pickup Persons

1st Contact/Pick Up

Name: _____ Phone: _____

Relationship to the Child: _____

Address: _____

2nd Contact/Pick Up

Name: _____ Phone: _____

Relationship to the Child: _____

Address: _____

3rd Contact/Pick Up

Name: _____ Phone: _____

Relationship to the Child: _____

Address: _____

Signature:

Parent Full Name: _____

Parent Signature: _____ Date: _____

Thank You!