

**NOTE: This document accompanies the learner through his/her years of schooling: (Please update termly or if any changes occurred)**

Admission nr: \_\_\_\_\_ Year: \_\_\_\_\_  
(Office use only)

**LEARNER INFORMATION: DATE:**

Surname: \_\_\_\_\_ No of children in immediate family: \_\_\_\_\_  
Names: \_\_\_\_\_ Prior attendance: \_\_\_\_\_  
(e.g. Nursery school)  
Sex: Female/Male \_\_\_\_\_ Previous Province: \_\_\_\_\_  
Child known as: \_\_\_\_\_ Birth Certificate no: \_\_\_\_\_  
(e.g. Entry no: 397/86/1813 – photocopy of  
Date of Birth: \_\_\_\_\_ birth certificate attached)  
Home language: \_\_\_\_\_ Language of learning and teaching:  
Afrikaans or English  
Ways of transport: \_\_\_\_\_

Foster care  Adopted/Orphan  Legal guardianship  Authority   
(Please attach proof e.g. letter of social worker) (Use "X" to mark where applicable)

Parents/Guardians (Relationship to learner)	Father/Guardian (If deceased attached copy of death certificate)	Mother/Guardian (If deceased attached copy of death certificate)
Surname and initials		
Marital status		
ID Number		
Occupation (Full/Part time) Company Name and address		
Physical Address	_____ _____	_____ _____
Postal address	_____ _____	_____ _____
Contact telephone numbers	Home: _____ Work: _____ Cell: _____ E-mail: _____	Home: _____ Work: _____ Cell: _____ E-mail: _____

**CONTACT PERSON (IN CASE OF EMERGENCY)**

Name & Surname: \_\_\_\_\_  
Phone / Cell number: \_\_\_\_\_  
Physical Address: \_\_\_\_\_

---

## PHYSICAL CONDITION / MEDICAL HISTORY

Clinic card submitted: YES  NO

(Use "X" to mark where applicable)

Family Practitioner/Doctor: \_\_\_\_\_

Tel no: \_\_\_\_\_

Allergies: (e.g. Penicillin)

---

---

---

Chronic illnesses: (e.g. Diabetics, Asthma); Diagnoses (autism, etc.)

---

---

---

Name of Medical Aid Scheme (if any): \_\_\_\_\_

Medical Aid number: \_\_\_\_\_

Name of member / Card holder: \_\_\_\_\_

## GENERAL INFORMATION THAT IS IMPORTANT

Is there any medication that must be given to learner during school? (Please describe)

---

---

Does your child receive any type of therapy e.g. Speech therapy / Physiotherapy / Occupational therapy

---

---

Does your child eat a special diet?

---

---

Is your child able to eat by him/herself?

---

---

Does your child know how to use the bathroom by him/herself?

---

---

Does your child use a wheelchair? Anything else we need to take note off?

---

---

IN THE INTEREST OF PROTECTING GENERAL HUMAN RIGHTS, THE CONFIDENTIALITY OF THIS DOCUMENT AND ITS CONTENTS MUST BE UPHELD IN TERMS OF RELEVANT LEGISLATION

