

PLEASE ATTACH A COPY OF YOUR MEDICAL AID CARD!!!

TO BE COMPLETED BY ALL PARENTS



A. PERSON RESPONSIBLE FOR THE ACCOUNT

SURNAME : _____

FULL NAMES : _____

ID NUMBER : _____

POSTAL ADDRESS: _____

EMPLOYER : _____

EMPLOYER ADDRESS: _____

CONTACT DETAILS : (____) _____ (H)

(____) _____ (W)

CELL _____

MEDICAL AID: _____

ADDRESS OF RELATIVE: _____

TEL/CELL NO RELATIVE: _____

DETAILS OF LEARNER

NAME: _____

DATE OF BIRTH: _____ GENDER: _____

ID NO: _____

ENTERED INTO GRADE: _____

SIGNATURE: _____ DATE: _____

C. MEDICAL HISTORY OF THE LEARNER

DOES YOUR CHILD SUFFER FROM OR DID HE / SHE HAVE ANY OF THE FOLLOWING DISEASES?

ASTHMA : _____ HEART DISEASE: _____

DIABETES : _____ BLOOD DISORDERS: _____

JAUNDICE: _____ EPILEPTIC: _____

ALLEGIES: _____

GENERAL COMMENTS ON ASPECTS OF YOUR CHILD'S HEALTH WHICH YOU WOULD LIKE TO DRAW TO OUR ATTENTION.

D. CONSENT:

In extremely urgent cases of illness or an accident where I cannot be consulted in time, I give my consent that the Principal, the Deputy or the Senior Housemaster/Mistress may take the necessary steps to call the best available doctor, or to take my child to hospital. Should a practicing physician regard an emergency operation and/or treatment essential, he/she may give his/her permission (consent) thereof on my behalf.

SIGNATURE : _____
(PARENT/GUARDIAN)

DATE: _____

