



ENROLMENT FORM

DATE OF ADMISSION REQUIRED: _____

<u>PARTICULARS OF CHILD</u>		
NAME:		
SURNAME:		
NICKNAME:		
GENDER:		
DATE OF BIRTH:		
HOME LANGUAGE:		
HOME TELEPHONE:		
HOME ADDRESS:	POSTAL ADDRESS:	
<u>PARTICULARS OF PARENTS</u>		
	FATHER	MOTHER
NAME:		
INITIALS:		
SURNAME:		
ID NO:		
HOME ADDRESS:		
HOME TELEPHONE:		
CELL NUMBER:		
OCCUPATION:		
EMPLOYER:		
WORK ADDRESS:		
WORK TELEPHONE:		
E-MAIL ADDRESS:		
MARITAL STATUS:		



<u>PARTICULARS OF CLOSE RELATIVE</u>	
NAME:	
SURNAME:	
ADDRESS:	
TELEPHONE:	
<u>MEDICAL INFORMATION OF CHILD</u>	
NAME OF MEDICAL DOCTOR/PEDIATRICIAN:	
TELEPHONE NO:	
CONTAGIOUS DISEASES THAT HE/SHE ALREADY HAD:	
DISEASES:	DATES:
IMMUNISATION:	
ALLERGIES:	
ANY OTHER PROBLEM THAT WE SHOULD KNOW ABOUT? (Epileptic, Diabetic etc)	
ANY OPERATIONS OR ACCIDENTS:	
PRESENT HEALTH CONDITION:	
ANY PHYSICAL ABNORMALITIES:	
<u>INFORMATION REQUIRED IN CASE OF MEDICAL/ HOSPITAL TREATMENT</u>	
NAME OF MEMBER:	
NAME AND ADDRESS OF EMPLOYER:	
MEDICAL AID FUND AND OPTION:	
MEDICAL AID NUMBER:	



INDEMNITY

We the undersigned, parents/guardians of
(Full name of child) herewith place my child, out of my own free will and at my own risk in the care of and hereby indemnify the principal and responsible persons from any liability, against any incidents or accidents, which might occur while my said child is in care of Loffieland Crèche. I am aware that all reasonable precautions will be taken for the safety of my child.

.....
Signature of parent/guardian

INFORMATION REQUIRED FOR CONSENT FOR EMERGENCY MEDICAL TREATMENT

I,.....PARENT/GUARDIAN OF

.....(FULL NAME AND SURNAME) cede my powers as parent/guardian to the principal of Loffieland Crèche, or her representative, should emergency medical/ surgical treatment be required for my child. As far as I know he/she is in a good state of health. In the event of the child requiring emergency medical treatment, I authorize Loffieland or its principal to consent to such treatment on my behalf. I understand that in case of such an event every effort will be made to contact the parent or guardian of the child first.

I accept that all reasonable precautions will be taken for the safety and wellbeing of my child and that I will be held responsible for paying any emergency medical and/or hospital accounts incurred on behalf of my child where applicable.

I also consent that the child may be transported to the nearest hospital or medical facility for medical attention, should the principal deem it necessary.

I do, however request the responsible persons to note the following: (Any particulars in connection with your child's state of health: allergies, epilepsy and other conditions, etc)

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.....
Signature of parent/guardian

.....
Date



AGREEMENT

I hereby apply for the above child to be enrolled at Loffieland Crèche. I have read the rules and regulations of the school, understand and accept it without any reservations. I agree to abide by:

- The conditions, rules and regulations as stated in the school rules and regulations, which are subject to change upon the necessary notice.
- Paying the school fees before the **3rd of each month** and I take note of the penalty for late payments.
- Paying penalty fee for collection after 17:30, which will be added to your account.
- The rule not to give notice in November, school fees being for 12 months of the year.
- The regulation to give **one calendar month written notice**.
- The responsible person hereby undertakes to pay attorney and own-client costs, should any legal steps arise from non-adherence to these rules.
- I acknowledge that in the event of my failure to pay all fees promptly, the school reserves the right to refuse my child entrance to the school.

Signed on the day of20__.

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Signature of parent/guardian/father

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Signature of parent/guardian/mother