THE AUTISM FOUNTAIN

Reg No: 257-400 NPO

11 Osborne Road
SELBORNE
5213

Cell no: 0784595343
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CHILD

NAME & SURNAME	
DATE OF BIRTH	
IDENTITY NUMBER	
TELEPHONE NUMBER	
RESIDENTIAL ADDRESS	

MOTHER / GUARDIAN / OTHER (Tick the applicable title)

NAME & SURNAME	
IDENTITY NUMBER	
TELEPHONE NUMBER	
RESIDENTIAL ADDRESS	
OCCUPATION	
PLACE OF EMPLOYMENT	
EMPLOYER PHYSICAL ADDRESS	
WORK NUMBER	

FATHER / GUARDIAN / OTHER (Tick the applicable title)

NAME & SURNAME	
IDENTITY NUMBER	
TELEPHONE NUMBER	
RESIDENTIAL ADDRESS	
OCCUPATION	
PLACE OF EMPLOYMENT	
EMPLOYER PHYSICAL ADDRESS	
WORK NUMBER	

NEIGHBOUR OR RELATIVE

NAME & SURNAME	

RESIDENTIAL ADDRESS	
TELEPHONE NUMBER	

MEDICAL AID DETAIL

MEDICAL AID	
MEDICAL AID NUMBER	
MAIN MEMBER	
HOSPITAL NAME	
FOLDER NUMBER	
ALLERGIES	
MEDICATION	

I wish to advise that my child suffers from / has the following chronic illness / condition:

TYPE OF ILLNESS/ CONDITION	TICK	PRESCRIBED MEDICATION	DOSAGE
Asthma			
Autism			
Blood disorder			
Cleft palate			
Diabetes			
Epilepsy			
Hearing defect			
Heart condition			
Cerebral palsy			
Is fitted with a stunt			
Kidney / bladder disorders			
Visual defects			
Other (specify – e.g. prone to attacks or migraine, etc.)			

My child is allergic to the following:

ALLERGY	MEDICATION	PROCEDURE TO BE FOLLOWED IN A CRISIS
Asprin		
Asthma (allergy)		
Bee sting		
Cats		
Dust		
Foodstuffs (specify)		
Medicines		
Other (specify)		

SIGNATURE PARENT / GUARDIAN: _____

NAME PRINT: _____ **DATE:** _____