THE AUTISM FOUNTAIN

Reg No: 257-400 NPO

11 Osborne Road
SELBORNE
5213

Cell no: 0784595343
Email: theautismfountain@gmail.com

Dear Prospective New Parent / Guardian

PLEASE NOTE THAT THE FOLLOWING DOCUMENTS MUST ACCOMPANY THIS APPLICATION FOR ADMISSION FORM

1.		A certified copy of child's birth certificate/identity document
2.		Certified copies of the identity documents of each parent or guardian
3.		Certified copy of the identity document of person responsible for the payment of fees if not the parent
4.		One recent ID colour photo of child
5.		Clinic Card
6.		If the child is currently at a school, then certified copies of the most recent academic reports, with the school's name and contact details clearly indicated
7.		Any other relevant reports, i.e. Psychologist, Medical Practitioner, Physiotherapist, Occupational Therapist and/or Referral from Hospital etc.

Thank you

_____

Nicolene Botha
Principal

THE AUTISM FOUNTAIN

APPLICATION FOR ADMISSION

CHILD'S DETAILS:

SURNAME:	
FULL NAMES:	
DATE OF BIRTH:	**PLACE OF BIRTH:**
IDENTITY NUMBER:	**GENDER:**
MOTHER TONGUE:	**ETHNIC GROUP:**
DOES CHILD UNDERSTAND AN INSTRUCTION GIVEN IN MOTHER TONGUE?	**YES:** **NO:**
IF NOT SOUTH AFRICAN, WHAT NATIONALITY?	
ADDRESS: Residential	
ADDRESS: Postal	
TELEPHONE NUMBER:	

Please circle the relevant answer: **EATING** **No support needed/Low level of support/ High level of support** **DRESSING** **No support needed/Low level of support/High level of support** **TOILET** **No support needed/Low level of support/High level of support**
Please circle the relevant answer: **MOBILITY** **Can run/walk/crawl/ dependent on assistive devices/in a wheelchair**

PARENT'S DETAILS

FATHER

SURNAME:	
FULL NAMES:	
IDENTITY NUMBER:	
ADDRESS: Residential	
ADDRESS: Postal	
TELEPHONE NUMBER:	**Home:**
	Cell:
	Fax:
	E-mail:
OCCUPATION:	
EMPLOYED BY:	
EMPLOYER'S ADDRESS	
TELEPHONE:	
FAX:	
Email:	

PARENT'S DETAILS

MOTHER

SURNAME:	
FULL NAMES:	
IDENTITY NUMBER:	
ADDRESS: Residential	
ADDRESS: Postal	
TELEPHONE NUMBER:	**Home:**
	Cell:
	Fax:
	E-mail:
OCCUPATION:	
EMPLOYED BY:	
EMPLOYER'S ADDRESS	
TELEPHONE:	
FAX:	
Email:	

SIBLINGS

NUMBER OF CHILDREN IN THE FAMILY:
HE/SHE IS NUMBER:
PLEASE LIST NAMES AND AGES: **1.** _____ **Date of birth:** _____ **2.** _____ **Date of birth:** _____ **3.** _____ **Date of birth:** _____ **4.** _____ **Date of birth:** _____

PREVIOUS INSTITUTIONS:

PLEASE LIST PREVIOUS INSTITUTIONS ATTENDED (INCLUDING PRE-SCHOOLS)	
NAME OF INSTITUTION	**LANGUAGE OF INSTRUCTION**
1.	
2.	
3.	
Highest standard passed, if mainstream school	
Last Phase, if school for Special Needs	
Please choose language of communication (English or Xhosa)	

MEDICAL INFORMATION

ALLERGIES:
MEDICATION TAKEN BY CHILD:
DOES HE/SHE SUFFER FROM EPILEPSY?
HAS HE/SHE ANY GENETIC DEFECTS?
ARE ALL IMMUNISATIONS UP TO DATE? **(Please include Clinic Card)**
PLEASE UNDERLINE ANY OF THE FOLLOWING DISEASES THAT YOUR CHILD HAS HAD: **Measles, German Measles, Whooping Cough, Mumps, Chicken Pox, Hepatitis**
FAMILY DOCTOR: _____ Tel no: _____ **SPECIALIST NAME: _____ Tel no: _____**
MEDICATION BEING TAKEN AT PRESENT: **NAME OF MEDICATION: _____** **PURPOSE: (Epilepsy/tranquilliser, etc) _____** **DOSAGE: _____** **_____**

MEDICAL AID INFORMATION

MEDICAL AID NUMBER	**MEDICAL AID NAME:**
MEDICAL AID MAIN MEMBER:	

DOCTOR'S NAME:	**DOCTOR'S PHONE NO:**
DOCTOR'S ADDRESS:	
MEDICAL CONDITIONS:	

CONSENTS:

CONSENT FOR PHOTOGRAPHS (Please underline)

1. **I hereby GIVE MY CONSENT/DO NOT GIVE MY CONSENT to have my child _____ (name of child) photographed, either for publication or display purposes or videoed in any activities associated with THE AUTISM FOUNTAIN.**
2. **I also GIVE MY CONSENT / DO NOT GIVE MY CONSENT that he/she may be named in any publications.**

SIGNATURE: _____ DATE: _____

PERMISSION TO TRAVEL IN STAFF CARS:

Please note that staff are covered for this eventuality in terms of our insurance policy.

☐ **I have no objection for my child being conveyed in the vehicle belonging to a member of staff**

☐ **I would prefer if my child is not conveyed in a staff vehicle**

SIGNATURE: _____ DATE: _____

FEES FOR THE AUTISM FOUNTAIN

I understand that the payment of fees is compulsory and agree to pay by the end of the first week of each month (or as by arrangement) or as indicated on payment option. I further hereby accept personal responsibility for the punctual payment of such school fees by appending my signature hereunder.

Signature of parent / legal guardian _____

INDEMNITY:

Although I am aware of the fact that trained staff members will be responsible for the transportation of children and will take all reasonable steps to prevent any injury or accident from taking part in activities or when he/she is a passenger in any transport arranged by The Autism Fountain, I will not hold the principal or any member of staff responsible for damages arising from injury or permanent disability which my child may suffer as a result of his/her taking part in activities or when he/she is a passenger in any transport arranged by The Autism Fountain.

Signature of parent / legal guardian _____

SPORT:

Please indicate whether you would like your child to take part in sport. (please tick the correct statement)

YES: I have no objection to my child taking part in sport.

NO: I do not want my child to take part in sport.

If your answer is NO, please give a reason why.

Signature of parent / legal guardian _____

GRANTS:

What is your relationship to the child? (Parent, grandmother, aunt, foster parent, etc.)

_____

Where are the child's legal parents? (if not filling in this questionnaire)

Father: _____

Mother: _____

Does the child receive a grant? _____

What kind of grant? _____

DECLARATION:

I, (full name of parent/ guardian) _____

Hereby declare that all the above information is accurate, to the best of my knowledge.

SIGNATURE: _____ DATE: _____

FOR OFFICE USE:

ADMISSION NUMBER: _____

DATE OF ADMISSION: _____