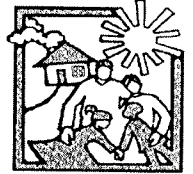


# SUNFIELD HOME SCHOOL (LANGHOLME)



FOR THE INTELLECTUALLY IMPAIRED

Association incorporated under section 21 of Companies Act, Reg. No.1996/003782/08  
024-885 NPO



P.O. Box 1975, Verulam, 4340; Physical Address: 7 Old Main Road, Canelands, Verulam; Tel: 032-5333632; Fax: 032-5337643  
E-mail: [sunfieldhomeschool@telkomsa.net](mailto:sunfieldhomeschool@telkomsa.net)

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DATE: .....

Thank you for your interest in our special little school, we trust we can be of assistance to you and your family.

Attached please find documentation which must be completed in full and returned to us with legible copies of the following essential reports/documents in order for an interview and assessment period to be considered.

- Birth certificate
- Psychologists report
- School reports
  
- Immunisation card
- Detailed medical report

Where applicable please include reports from:

- Occupational Therapist
- Physiotherapist
- Speech Therapist

Looking forward to meeting you and your special needs child,

SUNFIELD HOME SCHOOL ASSESSMENT COMMITTEE

.....  
MR P GOVENDER  
PRINCIPAL

**APPLICATION FOR ADMISSION TO SUNFIELD  
HOME SCHOOL**

<b><u>DATE OF APPLICATION</u></b>			
<b><u>CHILD'S INFORMATION</u></b>	<b><u>DETAILS</u></b>		
SURNAME			
FIRST NAMES			
ID NUMBER			
AGE			
DIAGNOSIS			
NATIONALITY			
HOME LANGUAGE			
RELIGION			
ALLERGIES			
<b><u>MEDICAL AID</u></b>			
NAME OF FUND			
NUMBER			
PRINCIPAL MEMBER			
<b><u>DOCTORS</u></b>			
PAEDIATRICIAN			
NEUROLOGIST			
GENERAL PRACTITIONER			
DENTIST			
OTHER			
<b><u>INFECTIOUS DISEASES</u></b>	<b><u>YES</u></b>	<b><u>NO</u></b>	<b><u>DATE</u></b>
MEASLES			
MUMPS			
RUBELLA/GERMAN MEASLES			
WHOOPING COUGH			
CHICKEN POX			
RHEUMATIC FEVER			
SCARLET FEVER			
HIV/AIDS			
HEPATITIS A,B, or C			
OTHER			

<b><u>MEDICAL HISTORY</u></b>	<b><u>DETAILS</u></b>		
SERIOUS ILLNESSES			
OPERATIONS			
INJURIES/ACCIDENTS			
CONVULSIONS/FITS			
PHYSICAL DISABILITY			
CEREBRAL PALSY			
HYPERACTIVE			
NOSE BLEEDS			
ALLERGIES			
<b><u>IMMUNISATIONS</u></b>	Please attach Clinic Card		
HEPATITIS B	YES [ <input type="checkbox"/> ]	NO [ <input type="checkbox"/> ]	DATE
OTHER	Details:		
<b><u>CURRENT MEDICATION</u></b>	<b><u>MEDICATION</u></b>	<b><u>REASON FOR TREATMENT</u></b>	
<b><u>PREVIOUS MEDICATION</u></b>	<b><u>MEDICATION</u></b>	<b><u>REASON FOR TREATMENT</u></b>	
<b><u>BIRTH HISTORY</u></b>	<b><u>DETAILS</u></b>		
APGAR SCORE			
BIRTH WEIGHT			
PROBLEMS AT BIRTH			
MOTHER'S PREGNANCY			
<b><u>MILESTONES</u></b>			
SAT AT			
CRAWLED AT			
WALKED AT			
TALKED AT			

<u>CHILD'S ABILITIES</u>	<u>GOOD</u>	<u>FAIR</u>	<u>WEAK</u>	<u>NEEDS HELP</u>	<u>UNABLE</u>
WALKING					
SPEAKING					
UNDERSTANDING					
DRESSING					
TOILETING					
FEEDING					
SWIMMING					
<u>OTHER</u>	<u>DETAILS</u>				
SLEEPING PATTERN					
BED WETTING					
CHILD'S FEARS					
FOOD LIKES AND DISLIKES					
MANNERISMS					
ANY OTHER INFORMATION					
<u>SCHOOLS ATTENDED</u>	<u>ADMISSION DATE</u>	<u>DISCHARGE DATE</u>	<u>REASON</u>		
NAME OF SCHOOL					
<u>UNSUCCESSFUL APPLICATION</u>	<u>NAME OF SCHOOL</u>	<u>DATE</u>	<u>REASON</u>		
<u>EMERGENCY CONTACT</u>	<u>NAME</u>	<u>NUMBER</u>	<u>RELATIONSHIP</u>		
<u>NEXT OF KIN</u>	<u>NAME</u>	<u>NUMBER</u>	<u>RELATIONSHIP</u>		

<b><u>FATHER'S DETAILS</u></b>	<b><u>DETAILS</u></b>		
SURNAME			
FIRST NAMES			
ID NUMBER			
DATE OF BIRTH			
PLACE OF BIRTH			
NATIONALITY			
MARITAL STATUS			
CUSTODIAL PARENT	YES [    ]    NO [    ]		
RESIDENTIAL ADDRESS			
TELEPHONE NUMBERS			
HOME			
WORK			
CELL			
E-MAIL			
HOME			
WORK			
FAX NUMBER			
HOME			
WORK			
OCCUPATION			
EMPLOYER			
WORK ADDRESS			
LENGTH OF SERVICE			
INCOME			
BELOW R 7,000 pm			
ABOVE R 7,000 pm			
ABOVE R 20,000 pm			
ADDITIONAL INCOME			
CHILD CARE GRANT			
DISABILITY GRANT			
OTHER			

<b><u>MOTHER'S DETAILS</u></b>	<b><u>DETAILS</u></b>
SURNAME	
FIRST NAMES	
ID NUMBER	
DATE OF BIRTH	
PLACE OF BIRTH	
NATIONALITY	
MARITAL STATUS	
CUSTODIAL PARENT	YES [    ]    NO [    ]
RESIDENTIAL ADDRESS	
TELEPHONE NUMBERS	
HOME	
WORK	
CELL	
E-MAIL	
HOME	
WORK	
FAX NUMBER	
HOME	
WORK	
OCCUPATION	
EMPLOYER	
WORK ADDRESS	
LENGTH OF SERVICE	
INCOME	
BELOW R 7,000 pm	
ABOVE R 7,000 pm	
ABOVE R 20,000 pm	
ADDITIONAL INCOME	
CHILD CARE GRANT	
DISABILITY GRANT	
OTHER	
<b><u>OTHER CHILDREN</u></b>	<b><u>NAME</u></b>
	<b><u>DATE OF BIRTH</u></b>

<b><u>GUARDIAN'S DETAILS</u></b>	<b><u>DETAILS</u></b>	
SURNAME		
FIRST NAMES		
RESIDENTIAL ADDRESS		
TELEPHONE NUMBERS		
HOME		
WORK		
CELL		
<b><u>FOLLOWING DETAILS</u></b>	<b><u>TO BE COMPLETED ONLY IF GUARDIAN RESPONSIBLE FOR FEE PAYMENT</u></b>	
E-MAIL		
HOME		
WORK		
FAX NUMBER		
HOME		
WORK		
OCCUPATION		
EMPLOYER		
WORK ADDRESS		
LENGTH OF SERVICE		
INCOME		
BELOW R 7,000 pm		
ABOVE R 7,000 pm		
ABOVE R 20,000 pm		
ADDITIONAL INCOME		
CHILD CARE GRANT		
DISABILITY GRANT		
OTHER		
<b>Kindly furnish any additional information you would like us to know about your child.</b>		

Empty rectangular box at the top of the page.

**SUNFIELD HOME SCHOOL (LANGHOLME)**  
**DECLARATION OF APPLICATION FOR ADMISSION**  
**(to be completed by the person who will be**  
**responsible for fee payments)**

I ..... declare that the particulars  
submitted in this application are, to the best of my knowledge, true and correct.

SIGNATURE.....DATE.....

WITNESS.....DATE.....

WITNESS.....DATE.....

*Thank you for your application*



