



APPLICATION FOR ADMISSION TO ETHEMBENI SCHOOL

- This form must be completed in full
- Completing this form does not mean that the child has been accepted to the school
- If the child is currently attending another school, do not remove him/her from school
- Section A – 1, 2 and 3 is to be completed by a parent/ guardian (learner details, family information and self help skills)
- Please write neatly. No tippex may be used

- **COMPULSORY FOR ALL LEARNERS:**
- Section B is to be filled in strictly by a medical practitioner
- The Ophthalmology form is to be filled in strictly by an Ophthalmologist/Optomestrist

Please attach a clear photocopy of the following:

1. Child's birth certificate
 2. Parent/guardian ID document
 3. Latest school reports
 4. Referral letter from current school
 5. Any medical reports (including psychological/therapy reports)
 6. Immunization records
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ISICELO SOKUFUNDA UKWAMUKELWA ETHEMBENI SCHOOL

- Leliform kumele ligcwaliswe lonke
- Ukugcwalisa leliform akusho ukuthi umntwana usethathiwe
- Uma umntwana kukhona lapho efunda khona, sicela ungamkhiphi kuleso sikole aze abizwe eThembeni School
- Section A – 1, 2 & 3 igcwaliswa umzali/noma obheke umntwana imniningwane yomntwana, neyomndeni nokuthi yikhiphi akwazi ukuzenzela kona.
- Section B – kumele agcwaliswe u-Dokotela lokho kubalulekile kakhulu
- Kunelinye ifomu eligwaliswa u-Dokotela wamehlo eligcwalisela umntwana
- Uyacelwa ubhale ngokucacile. Ungaxikizi ungathiphexi.

- Uyacewla ukuba uphathe lezizinto ezilandelayo:
- 1. Isitifiketi sokuzalwa komntwana
- 2. Ikhophi yepasi lomzali noma obheke umntwana
- 3. Iriphothi lomntwana lesikole
- 4. Incwadi ethumela umntwana kuthina etholakala esikoleni akuso umntwana
- 5. Uma ikhona ikhophi noma iyiphi yencwadi ephuma udokotela yomntwana ngabe eyokugula noma uhlinziwe, iphathe.
- 6. Ikhadi lokugoma umntwana

APPLICATION FOR ADMISSION TO SCHOOL

ETHEMBENI SCHOOL FOR THE PHYSICALLY DISABLED AND VISUALLY I

GLD MAIN ROAD

Telephone: 074 - 1278069

CATO RIDGE

Fax: 086 - 5728914

3870

Year: _____

Note: This form must be completed in full. All changes to be initialed or signed by parent / guardian. Completing the form does not necessarily mean that the learner has been accepted into the school.

Grade Applied For:	Highest Grade Passed	Year When Grade was passed:	Accession No:
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Surname:	Initials:	Nick Name:
First Name:	Other Names:	
Date Of Birth: YYYY	MM	DD
Race:	Gender:	Male: Female:
Country of Residence:	Identification or Passport No:	
If SA, indicate province of residence:	Citizenship:	

Physical Address:	Home Telephone:
City/Suburb	Emergency Telephone:
Code:	Learner Cell:
Learner Email Address:	

Home Language:	Preferred Language of Instruction
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Boarder	Yes	No
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Deceased Parent	Mother	Father	Both	Mode of transport:
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Religion:	For Grade 1 only: Indicate pre-primary education	None	Non Formal	Formal
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Previous School Information

Name of Previous School:		
Previous School Address:		
Code:	Province:	Country:

Learner Medical Information

Medical Aid Number:	Medical Aid Name:					
Medical Aid Main Member:	Doctor Name:					
Doctor's Address:	Doctor Telephone Number:					
Medical Condition:						
Special Problems Requiring Counseling:						
Dexterity of Learner:	Right Handed	Left Handed	Ambidextrous	Reg. Social Grant	YES	NO:
				Rec. Social Grant	YES	NO:

If the learner is accepted, the following documents must be submitted to the school:

- | | |
|---|---|
| 1. Copy of Immunisation Records. | 2. Copy of Birth Certificate |
| 3. Progress Report from Previous School | 4. Transfer Letter from Previous School |

Siblings	
Number of other Children at this school: <input type="text"/>	Position in the family (e.g first): <input type="text"/>
Please supply full names below:	
Name: <input type="text"/>	Grade: <input type="text"/>
Name: <input type="text"/>	Grade: <input type="text"/>
Name: <input type="text"/>	Grade: <input type="text"/>

Parent / Guardian Information		Complete a SEPARATE parent form for each parent living at a different physical address	
Title: <input type="text"/>	Initials: <input type="text"/>	Surname: <input type="text"/>	
First Name: <input type="text"/>	Gender: <input type="text"/>	Male: <input type="text"/>	Female: <input type="text"/>
Home Language: <input type="text"/>	Race: <input type="text"/>		
Identification Number: <input type="text"/>	Or Passport number	Account Payer: <input type="text"/>	Yes <input type="text"/> No <input type="text"/>
Residential Street Address: <input type="text"/>			
<input type="text"/>		City/Suburb <input type="text"/>	Code: <input type="text"/>
Occupation: <input type="text"/>	Employer: <input type="text"/>		
Surname of Spouse: <input type="text"/>	First Name: <input type="text"/>		
Occupation of Spouse: <input type="text"/>	Learner resides with this parent/s	Yes <input type="text"/>	No <input type="text"/>
Spouse ID Number: <input type="text"/>	Relationship to Learner: <input type="text"/>		
Marital status of parent: <input type="text"/>			

Correspondence Details	
Title: <input type="text"/>	Surname: <input type="text"/>
Postal Address: <input type="text"/>	
<input type="text"/>	City/Suburb <input type="text"/>
Code: <input type="text"/>	

Other Contact Details	
Home Telephone <input type="text"/>	Work Telephone <input type="text"/>
Fax Number: <input type="text"/>	Cell Number: <input type="text"/>
Spouse Work Telephone Number: <input type="text"/>	Spouse Cell Number: <input type="text"/>
E-Mail Address: <input type="text"/>	Spouse E-Mail Address: <input type="text"/>

I hereby declare that to the best of my knowledge, the above information as supplied is accurate and correct.

Name of Parent / Guardian (Please Print): _____

Signature of Parent / Guardian _____

Date: _____/_____/_____

Office use only:			
1. Date: <input type="text"/>	2. Accepted: <input type="text"/>	3. Accession Number: <input type="text"/>	
4. Rejected: <input type="text"/>	5. Reason for Rejection: <input type="text"/>		
6. Documentation Received: <input type="text"/>	6a Immunisation Record: <input type="text"/>	6b. Birth Certificate: <input type="text"/>	
6c. Progress Report from Previous School: <input type="text"/>		6d. Transfer Letter from Previous School: <input type="text"/>	

SECTION A – 3. SELF HELP SKILLS

TOILETING

Does the child tell you when he/she needs the toilet	YES	NO
Does the child need help getting on/off the toilet	YES	NO
Does the child need help wiping and cleaning	YES	NO
Does the child need help changing nappies	YES	NO
Does the child need help disposing of used nappies	YES	NO

INDEPENDENCE

Does the child need help getting on/off the bed	YES	NO
Does the child need help getting on/off wheelchair	YES	NO
Does the child need help getting on/off normal chair	YES	NO
Does the child need help bathing	YES	NO
Does the child need help getting dressed	YES	NO
Does the child need help eating and drinking	YES	NO
If partially sighted/blind, can the child find their way	YES	NO

Name and signature of parent/guardian

Applicants Name: _____

Ethembeni School for the Physically Disabled and Visually Impaired



ETHEMBENI SCHOOL
FOR THE PHYSICALLY DISABLED AND VISUALLY IMPAIRED

Private Bag X 7021
Hillcrest 3650
E-Mail: ethembeni@mweb.co.za
Website: www.ethembenischool.co.za

☎ (074) 1278069
☎ (074) 1746987
Fax: 0862462308/0865728914

MEDICAL REPORT (to be completed by a medical practitioner)

BIRTH HISTORY

Parents age at child's birth	Mother:		Father:	
Comments on delivery (NVD/Caesar/complications)				
Comments on pre/post natal history				
Developmental milestones – ages at which each occurred	Sit	Crawl	Walk	Talk

PHYSICAL EXAMINATION

Child's weight	
Are the sounds, pulse and rhythm of the heart normal	
Is the child free from any contagious disease	
Are the teeth in good condition	
Are tonsils/adenoids affected in any way	
Are there any signs of pressure sores	
Are the lungs normal	
Does the child suffer from epilepsy	
If yes, frequency and duration of seizures/triggers	
List conditions being treated currently	
Has the child ever been hospitalised/had any surgery? Please provide dates, details and reasons	

Applicants Name: _____

<i>MEDICATIONS</i>			
NAME	DOSAGE		REVIEW DATE
<i>PHYSICAL DISABILITY (tick applicable, provide details below)</i>			
Cerebral Palsy	Post Meningitis	Spina Bifida	
Marfins Syndrome*	TB Spine	Muscular dystrophy	
Club feet	Amputee	Hemiplegia	
Other:			
Cause of disability:	Birth	Illness	Trauma
Date and age of onset:			
<i>*If Marfins, has the child been screened for cardiac problems/other related conditions:</i>			
<i>RESTRICTIONS WITH REGARD TO PARTICIPATION IN SPORTS (tick if applicable)</i>			
Contact sport e.g Judo	Athletics	Horse riding	Soccer
Swimming	Basketball	Other (specify):	
Further recommendations:			
<i>MOBILITY</i>			
Walks independently or walks with an aid			
Specify aid used if applicable			
Does the child have a wheelchair			
<i>VISION</i>			
Is there a visual defect? If yes specify			
Age of onset	Prognosis:	Stable	Deteriorating
Previous eye surgery – date and nature			
Is further surgery recommended? Specify			

Applicants Name: _____

<i>SPEECH & HEARING</i>			
Is there a defect in hearing	YES	NO	
Has the child been for a hearing test (if yes, please attach results)	YES	NO	
Is there a defect in speech	YES	NO	
If yes, what is the severity	Mild	Moderate	Severe
Recommendations			

<i>INTELLECT</i>			
Do you consider the child intellectually normal	YES	NO	
If no, what is the severity of impairment	Mild	Moderate	Severe

<i>PLACEMENT RECOMMENDATION</i>	
Which of the following do you consider the applicant suitable for (please tick):	
School for the intellectually impaired	School for the visually impaired
School for the physically disabled	School for the hearing impaired
Mainstream School	Other

<i>DETAILS OF MEDICAL PRACTITIONER</i>	
Name (block letters)	
Qualifications	
Contact details	Phone: Email: Fax:
Signature	
Date	
Private Practice no.	Hospital Stamp

Applicants Name: _____



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OPHTHALMOLOGY /OPTOMETRY ASSESSMENT

NB: This form is to be completed by an Ophthalmologist/Optomestrist for all applicants

Name of child	Date of birth
Diagnosis	

Visual Acuity

	Distance		Near	
	Unaided	WRx	Unaided	WRx
R.E.				
L.E.				
Both eyes				

Spectacle Rx	Sphere	Cyl	Axis	Add	PD
R.E.					
L.E.					

Rx ordered: Yes/No _____ If yes, date for collection _____
Colour Vision Normal: Yes/No _____
Visual Fields Normal: Yes/No _____

FOR LOW VISION PATIENTS

Is the condition likely to cause *near vision* to deteriorate significantly? If yes please provide as much detail as possible.

Recommendations/Additional Comments _____

Practitioner Name and Qualification (Please print) _____

Signature _____

Date _____

Hospital/Clinic/Practice Stamp

ETHEMBENI SCHOOL FOR THE PHYSICALLY DISABLED AND VISUALLY IMPAIRED

APPLICATION FOR HOSTEL ACCOMMODATION

(Please note completion of this form does not mean automatic acceptance for Hostel accommodation)

Date: _____

Grade: _____ Disability: _____

Surname: _____

Full names: _____

M	F
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Disability grant: Yes No

OTHER MEDICAL CONDITION/S AND MANAGEMENT

Medication: List all medication /treatment

Medication	Strength	Dose	Time given

Where is the medicine obtained from? _____

Name of Clinic/Hospital/Doctor: _____

Who collects the medication?: _____

When is the next appointment date?: _____

Who will be responsible to bring the medication monthly to school?:

Name: _____ Contact No/s: _____

ALLERGIES

Is your child/ward allergic to any medicines or food. Please list

Medicines: _____

Food: _____

Does your child wear nappies? No Yes

If yes: State how you would ensure regular supply of the nappies to the school

Number of nappy changes per day: _____

Is your child using any of the following:-
State YES or NO

Calipers (Irons)	Yes	No
Wheelchairs	Yes	No
Crutches	Yes	No
Walkers or strollers	Yes	No
Tested Spectacles	Yes	No
Hearing Aids	Yes	No
Colostomy Bag	Yes	No
Trachistomy	Yes	No
Other/s: Please specify	Yes	No

PARENT/GUARDIAN INFORMATION FOR HOSTEL FEES

MOTHER

FATHER

Surname:	Surname:
Full Names	Full Names:
ID No:	ID No:
Contact No:	Contact No:
Occupation	Occupation:
Address: (postal)	Address: (Postal)
Address: (Home)	Address: (Home)

FOR ETHEMBENI SCHOOL USE ONLY

Assessment No: _____

Levels of support: _____

Hostel: _____

Recommendation of Hostel Manager: _____

Signature
Hostel Manager/superintendent

Date