



ETHEMBENI SCHOOL

FOR THE PHYSICALLY DISABLED AND VISUALLY IMPAIRED

Private Bag X 7021

Hillcrest 3650

☎ (031) 9421783

☎ (086)1499611

Fax: (086)246 2308/0865728914

E-Mail: ethembeni@mweb.co.za

APPLICATION FOR ADMISSION TO ETHEMBENI SCHOOL

Please note:

1. Only **FULLY completed** application forms, **accompanied by the documents requested below**,* will be considered.
2. If you are applying for a learner who has **known intellectual impairment**, kindly contact the Special Needs Education Service (SNES) of the Department of Education for assistance. Ethembeni School will be **unsuitable** for the child.
3. Completing this form does **not** mean that the child has been accepted to the school.
4. If the child is currently in school, he or she should **remain in that school** until alternative placement has been **officially confirmed**.

How to Complete Application Form

1. **Section A: Parent/guardian** to provide information and signature.
2. **Section B: Registered medical officer (doctor)** to complete.
3. **Section C: Therapist** (To expedite completion, any available therapist may assist.)
4. **Ophthalmology/Optometry Report: Registered Ophthalmologist/Optometrist.** This form is **compulsory for ALL applicants**, not only applicants with a visual impairment.
5. **Please note: No correction fluid** may be used (e.g. Tippex).

*Documents To Be Attached To Application Forms

Clear copies of the following:

1. Child's **birth certificate**
2. Parent's/guardian's **ID document**
3. Any additional **medical/psychology/therapy reports**
4. **Immunisation records** (Road to Health)
5. **If child is in or has been in school:**
 - a) Most recent **school reports** (up to last 2 years, if applicable)
 - b) **Referral letter** from current school

Submission of Completed Forms

1. Fully completed application forms, together with all requested documentation, may be **dropped off at Ethembeni School or faxed/emailed**.
2. Parents/guardians will be informed within **approximately 2 weeks** of receipt of application, whether or not the child will be interviewed at school.

The interview includes **scholastic and therapy screening**, aimed at assessing whether the child meets the school's **admission criteria**, and **whether or not the child's needs can be met by the school**.

Interviews will be conducted on **Thursdays mornings, by appointment only**. (For further details, please see our Admission and Policy Procedure.)



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ISICELO SESIKHALA SOKUFUNDA

QAPHELA

1. Ngamafomu agcwaliswe ngokuphelele kuphela futhi ehambisana neminingwane efanele ayokwamukelwa.
2. Uma ubheka isikhala somntwana okhubazeke ngokomqondo kungabangcono ukuthi uthintane nabe Special Needs Education Service (SNES) kwa Department of Education Isikole sase Ethembeni asibalungeli abantwana abanjalo.
3. Ukugcwaliswa kwalelifomu akusho ukuthi umntwana sesimamukele.
4. Uma umntwana efunda kwesinye isikole, makangakhishwa kuze kutholakale indawo kwesinye.

UKUGCWALISWA KWEFOMU

1. Section A – 1, 2 NO 3 Igcwaliswa umzali/noma osesikhundleni futhi oneminingwane yengane.

Section D – Kumele ugqwaliswe uDokotela wamehlo ogunyaziwe. Wonke amafomu kufanele agcwalise ngu Dokotela kanye nawabakhubazekile.

2. Mzali kubalulekile ukubhala ngesandla esifundekayo esingaxikiziwe.

Umzali uyacelwa ukuba aphaathe lokhu okulandelayo:

1. Isitifiketi sokuzalwa kontwana.
2. Ikhophi yepasi lomzali noma osesikhundleni somzali.
3. Iriphothi lomntwana lesikole.
4. Ikhadi lomgomo
5. Uma ingane ifunda kwesinye isikole sicela aphaathe lokhu okulandelayo:
 - 5.1 Incwadi eshoyo ukuthi uphuma kusiphi isikole.
 - 5.2 Iriphothi lokugcina kuya eminyakeni emibili.



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APPLICATION FOR ADMISSION TO ETHEMBENI SCHOOL

(Please read the cover page before completing this form)

SECTION A To be completed by parent/guardian

Learner's Surname

Learner's Full Names

Name Learner Is Called By

Learner's ID number

Age:

Gender

Male

Female

Home Language:

Learner's Home Address (Where learner actually lives.)

Postal Address (include code)

Place Of Learner In Family (circle)

Only child first born 2nd 3rd 4th 5th _____

Number of siblings

Nearest hospital

Nearest clinic

Family doctor + Phone number

Nearest welfare office

Referred by

Tel:

Allergies

Medical aid -if applicable

Grant received

No

Yes - Type of grant:

SCHOOLING HISTORY

If attends/attended:

Creche: Name _____ Date started _____ Ended _____ Tel: _____

Preschool: Name _____ Date started _____ Ended _____ Tel: _____

Reasons for leaving creche/preschool (Tick): Too old ___ Was asked to leave ___ Parent/guardian unhappy ___

Child did not enjoy ___ Other _____

Was child taught: Counting? Yes / No Shapes? Yes / No Colours? Yes No

If attends/attended School: Name of current school _____ Tel: _____

Grade child is doing at present _____ Grade(s) repeated _____ Year(s) _____

Name of previous school (s) _____ Year started _____ Year ended _____

Does child require hostel accommodation? (Our hostels are for term time only) Yes No		
Religion		
INDEPENDENCE		
Does the child tell you when he/she needs the toilet?	NO	YES
Does the child need help getting on/off the toilet/chair/bed?	NO	YES
Does the child need help wiping and cleaning after toileting?	NO	YES
Does the child need help changing nappies?	NO	YES
Does the child need help bathing?	NO	YES
Does the child need help getting dressed?	NO	YES
Does the child need help eating or drinking?	NO	YES

FAMILY INFORMATION			
Father / Male Guardian Details			
Surname		Name(s)	
Contact numbers	Cell:	H:	W:
Occupation			
Home language			
Physical address			
Postal address			
Email address			
Mother / Female Guardian Details			
Surname		Name(s)	
Contact numbers	Cell:	H:	W:
Occupation			
Home language			
Physical Address			
Postal Address			
Email address			

Name of Parent/Guardian who provided above details _____

Signature _____

Child's Name: _____ Ethembeni School for the Physically Disabled and Visually Impaired 2 of 5

SECTION B MEDICAL REPORT to be completed by a Registered Medical Officer**(Kindly complete both pages.)****Physical Examination**

Developmental milestones(age achieved): Sit _____ Crawl _____ Walk _____ Talk _____

Child's weight: _____

Does child have a cardiac condition? Please specify: _____

Is the child free from any contagious disease?

Yes No

Are the teeth in good condition?

Yes No

Are tonsils/adenoids affected in any way?

Yes No

Are there any signs of pressure sores?

Yes No

Does child suffer from asthma?

Yes No

Known Allergies: _____

Does the child have epilepsy Yes No

If Yes, please give details of type, frequency of seizures, etc.: _____
_____Please detail any surgical devices in place (E.g. V-P Shunt) _____
_____Date(s) and nature of previous/planned surgery: _____
_____Recommended medical referrals/follow-up: _____
_____**Current Medications:**

Name	Dosage	Review Date

Cause of Disability (please tick relevant condition(s))

Cerebral Palsy _____ Type _____

Muscular dystrophy _____ Type _____

Spina Bifida _____

Osteogenesis Imperfecta _____

Club feet _____

Amputee _____ (Please specify) _____

Marfan Syndrome _____ (Has child been screened for cardiac/other related conditions? **Y N**)

Visual Impairment _____

Other: _____

Date and age of onset of condition: _____

SECTION B (Continued)**Lower Limbs (For Physical Disabilities only)**

If **independently ambulant**, please indicate quality of gait and speed (circle):

normal at all times on all terrains; problematic on uneven terrain/steps; excessively slow; uncoordinated; other: _____

Mobility aid(s) required (circle): walker; crutches (1 / 2); self-propelled wheelchair; buggy;

Other: _____

Upper Limbs: Is child physically able to use pen and paper? **Yes No**

Speech and Hearing

Has the child had a hearing test? (If yes, please attach results) **Yes No**

Based on observations, is there any apparent/suspected hearing defect? **Yes No**

Is child's speech intelligible? **Yes No**

Intellect

Has child ever been assessed by/referred to a psychologist? **Yes No**

Do you suspect intellectual impairment? **Yes No**

If yes, in your opinion, what is the severity of impairment? (Please circle): **Mild Moderate Severe**

Sports

Please indicate any sports that should be avoided for medical reasons:

Contact sports (e.g. Judo) Swimming Sprinting Horse Riding Soccer Other: _____

Placement Recommendation

Which of the following types of school are, in your opinion, **most suited** to the applicant (please tick):

School for learners with **intellectual impairment** _____

School for learners with **physical disability** _____

School for learners with **visual impairment** _____

School for learners with **hearing impairment** _____

Details Of Medical Officer

Name (block letters)

Qualifications

Contact details

Phone _____

Email _____

Fax _____

Signature _____ Date _____

Private Practice No. (If applicable) _____

Hospital Stamp:

Thank you.

Child's Name: _____ *Ethembeni School for the Physically Disabled and Visually Impaired 4 of 5*

SECTION C: Basic Concepts Questionnaire (To be completed for applicants from age 5 to 10 years, by any available therapist)

Dear Therapist.

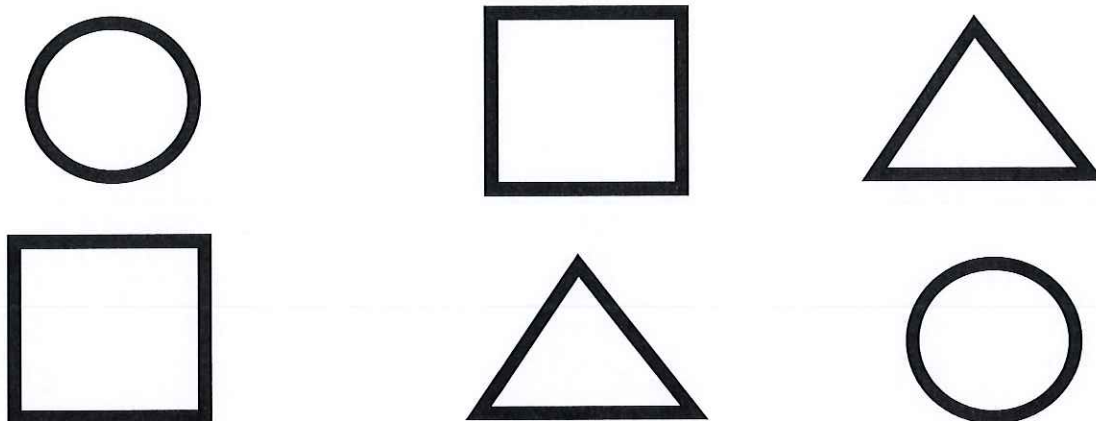
Thank you for your kind assistance in completing this questionnaire, which forms part of the application form for **Ethembeni School for the Physically Disabled and Visually Impaired**. Please feel free to attach any existing reports (past/present) regarding the child.

Kindly note: We offer a **mainstream curriculum** that would be **unsuitable** for learners with intellectual impairment.

Name of Child _____ Date of Birth _____

1. **Body Parts** (Please circle): Child can **independently** indicate: **Head Eyes Nose Ears Arms Hands Legs Feet**
Body functions (Please circle child's answer): Do we walk with our ears? **Yes / No**
Do we eat with our nose? **Yes No**

2. **Matching** (For learners with visual impairment, kindly use 3D shapes if possible. If not, omit)
Can child correctly match the following shapes without assistance? (*Child/therapist may link shapes with lines*)



Did child have difficulty in understanding how to match? **Yes / No**

Please indicate which shapes child can independently identify/name: **Square Triangle Circle**

Additional shapes identified (if presented): _____

3. **Rote Counting** Kindly indicate last number reached with **no errors or assistance** (max 30)
1 - _____ **Object counting** (max 10) **1 - _____**

4. **Reasoning and classification:** Child can name 3 animals? **Y N** 3 things to eat? **Y N**

5. **General Interaction**

- **Attention:** Satisfactory Poor _____
- **Cooperation:** Satisfactory Poor _____
- Child appeared to understand all / most / few of the instructions given?
Language used to communicate with child for above purposes: **isiZulu/ English /Other** _____

6. Kindly indicate your opinion on **suitable school placement** for this child (please circle): **School for Learners with Intellectual impairment/ Physical disability / Visual Impairment / Full Service School / Mainstream School.**

7. **Additional Comments?** _____

Name of Therapist (please ring: OT PT ST) _____ Signature _____

Institution _____ Contact Number _____

Thank you.

Child's Name: _____ Ethembeni School for the Physically Disabled and Visually Impaired **5 of 5**



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OPHTHALMOLOGY ASSESSMENT

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

Name of child	
Date of birth	
Diagnosis	

VISUAL ACUITY

	DISTANCE VISION		NEAR VISION	
	Unaided	WRx	Unaided	WRx
R.E.				
L.E.				
Both eyes				

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

Colour Vision Normal: Yes/No _____

Visual Fields Normal: Yes/No _____

Rx ordered: Yes/No _____ If yes, date for collection _____

Additional Comments: _____

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: _____

Hospital/Practitioner and Qualification: _____ Date: _____

Name (print): _____ Signature: _____

Hospital/Clinic/Practice Stamp

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