APPLICATION FORM

CHILD INFORMATION

Surname _____ Initials _____

First Name _____ Gender (Male / Female)

Preferred Name _____ Home Language_____

Date of Birth _____/_____/_____ Current Age _____/_____
Day Month Year Year Months

Referred by _____

Please mark with an X which option you prefer:

Full Day (Mon – Fri) ☐ Half Day (Mon-Fri) ☐

ADDITIONAL INFORMATION

Medical Aid Yes / No

Medical Aid Name _____

Medical Aid Number _____

Doctor's Name _____

Doctor's Number _____

Known Disability _____

Is your Child on medication? Please give details

_____

_____

_____

OWL DAY CARE
4 Douglas Road, Bedfordview, 2007
PostNet Suite # 135 Private Bag X782. Bedfordview,2008
Tel: 011 450 1630 E-mail: info@owldaycare.co.za
Monika Wassermeier (Managing Director), Barbara Wassermeier (Director)
OWL School (Pty Ltd)
Company Reg # 2015/373504/07

Known Allergies/Medicine intolerance

_____

_____

_____

Please give details of any childhood illnesses e.g. Measles, mumps, chicken pox, asthma, eye or ear problems?

_____

_____

_____

Please give details of any high fevers, seizures or convulsions your child may have had or has

_____

_____

_____

Please give details of any food habits, eating routine that are of a concern to you.

_____

_____

_____

Are there any Behavioral issues or traits that we should know of e.g. meltdown, hitting, biting, issues with siblings etc.

_____

_____

_____

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DIETARY REQUIREMENTS

If your child is on a prescribed feeding program, please explain what the dietary requirements or plan are and feeding times please

_____

_____

_____

PRESENT ACTIVITIES

DOES YOUR CHILD DO THE FOLLOWING, PLEASE ANSWER YES OR NO

MOTOR SKILLS

- Wheelchair bound _____
- Sit momentarily alone _____
- Crawl Alone _____
- Walk Alone _____
- Eats & Drinks alone _____

SPEECH AND LANUGUAGE SKILLS

- Babbles _____
- Says a few words _____
- Does not talk at all _____
- Any Eye Condition _____
- Any Hearing Issues _____

TOILET TRAINED _____

If not, please discuss with us where you are at with toilet training so that we can continue with a routine or start a toilet training routine.

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PRESENT TRAITS AND BEHAVIOURS

Please select your child's characteristics and behaviors with an x

Clumsy	Average Mobility	Normal Mobility
Difficulty with Pencil tasks	Average Pencil use	Good with Pencil tasks
Difficulty expressing verbally	Average expressive Language	Expressive Language
Withdrawn/prefers to be alone	Friendly	Very Social
Inattentive inability to focus	Average ability to focus	Concentrate very well
Impulsive or explosive	Average Temperament	Calm even tempered
Excessively dependent	Average	Overly independent
Excessively Fearful	Has normal fears	Fearless
Depressed	Normal Behavior	Extremely cheerful
Responds well to discipline	Only responds to some people	Discipline problem

Does your Child have a sleep pattern during the day? If Yes, please explain

Please supply the Day Care with a copy of the vaccination card and any Dr reports that will assist the Day Care in caring for your child.

PARENTAL INFORMATION

	Primary Parent/Guardian	Secondary Parent/Guardian
Surname	_____	_____
First Name	_____	_____
Relationship to Child	_____	_____
I.D Number	_____	_____
Date of Birth	_____	_____
Home Address	_____	_____
	_____	_____
Postal Address	_____	_____
	_____	_____
Occupation	_____	_____
Work Address	_____	_____
Telephone # Home	_____	_____
Telephone # Work	_____	_____
Telephone # Cell	_____	_____
E-Mail Address	_____	_____

EMERGENCY CONTACT NUMBERS (other than parents)

Name & Surname _____

Telephone # Home _____

Telephone # Work _____

Telephone # Cell _____

and

Name & Surname _____

Telephone # Home _____

Telephone # Work _____

Telephone # Cell _____

Signature _____ Date _____

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