



# Fish Hoek Primary School

ESTABLISHED 1928

GRADES: Pre R - 7

## PRE-Grade R Enrolment

LEARNER:	
DATE OF BIRTH:	
STARTING DATE:	

<b>Documents Required:</b>	<b>tick</b>	<b>Received by:</b>
Child's Birth Certificate/ID: (Certified Copy)		
Parent 1 ID/Passport: (Certified Copy)		
Parent 2 ID/Passport: (Certified Copy)		
Proof of Residential Address:		
Clinic Card/Immunisation Certificate:		

<b>FOR OFFICIAL USE ONLY:</b>	
Date of Receipt of Application:	
Allocated Class:	
Principal's Signature:	

It's all about our kids

T: (021) 782-6113 F: (021) 782-2326 • Address: Upper Recreation Road, Fish Hoek, 7975

E: reception@fishhoekprimary.co.za • www.fishhoekprimary.co.za • Fish Hoek Primary School @fishhoekpri

**CHILD'S DETAILS** (please print clearly)

FIRST NAME:

MIDDLE NAME:

SURNAME:

ID NUMBER:

DATE OF BIRTH:

GENDER: (MALE/FEMALE)

PHYSICAL HOME ADDRESS:

POSTAL ADDRESS:

PRESENT SCHOOL (if applicable):

HOME LANGUAGE:

BROTHERS &amp; SISTERS AT FHPS:

NAME:

GRADE:

NAME:

GRADE:

BROTHERS & SISTERS  
AT OTHER SCHOOLS:

NAME:

GRADE:

SCHOOL:

NAME:

GRADE:

SCHOOL:

NAME:

GRADE:

SCHOOL:

**MEDICAL DETAILS**

MEDICAL DOCTOR'S NAME:

TELEPHONE NUMBER:

DO YOU HAVE MEDICAL AID:

YES NO MEDICAL AID SCHEME &  
NUMBER:MAIN MEMBER'S NAME &  
SURNAME:IF REQUIRED, MY CHILD MUST  
BE TAKEN TO A: (please circle)

PRIVATE HOSPITAL

STATE HOSPITAL

NAVAL HOSPITAL

**NB: ALL COSTS FOR PARENTS' OWN ACCOUNT****CAPE MEDICAL RESPONSE MEMBER:** YES NO 

Membership Number:

**ALLERGIES:****DIETARY REQUIREMENTS:****AFTERCARE**

Will your child be attending FHPS's Aftercare?

 YES NO

**FAMILY INFORMATION** (please print clearly)**MARITAL STATUS** (please indicate with an )MARRIED ANC / MARRIED CoP  DIVORCED/SEPARATED REMARRIED  LIFE PARTNERS SINGLE  SPOUSE DECEASED CHILD RESIDES WITH: MOTHER  FATHER  BOTH PARENTS 

OTHER (please specify): \_\_\_\_\_

**FIRST PARENT/GUARDIAN****SECOND PARENT/GUARDIAN**

RELATIONSHIP TO LEARNER: (please indicate with an <input checked="" type="checkbox"/> )	PARENT: <input type="checkbox"/> LEGAL GUARDIAN: <input type="checkbox"/> GRANDPARENT: <input type="checkbox"/> STEP PARENT: <input type="checkbox"/> OTHER: _____	RELATIONSHIP TO LEARNER: (please indicate with an <input checked="" type="checkbox"/> )	PARENT: <input type="checkbox"/> LEGAL GUARDIAN: <input type="checkbox"/> GRANDPARENT: <input type="checkbox"/> STEP PARENT: <input type="checkbox"/> OTHER: _____
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GENDER:	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	GENDER:	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
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TITLE:		TITLE:	
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FIRST NAME:		FIRST NAME:	
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SURNAME:		SURNAME:	
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ID/PASSPORT NUMBER:		ID/PASSPORT NUMBER:	
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PHYSICAL ADDRESS:		PHYSICAL ADDRESS:	
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POSTAL ADDRESS: (if differs from physical address)		POSTAL ADDRESS: (if differs from physical address)	
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HOME:		HOME:	
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WORK:		WORK:	
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CELLPHONE:		CELLPHONE:	
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E-MAIL ADDRESS:		E-MAIL ADDRESS:	
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OCCUPATION:		OCCUPATION:	
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EMPLOYER:		EMPLOYER:	
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EMPLOYER'S ADDRESS:		EMPLOYER'S ADDRESS:	
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EMPLOYER'S TEL. NO.:		EMPLOYER'S TEL. NO.:	
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COMMUNICATION FROM SCHOOL:	SMS <input type="checkbox"/> E-MAIL <input type="checkbox"/>	COMMUNICATION FROM SCHOOL:	SMS <input type="checkbox"/> E-MAIL <input type="checkbox"/>
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**ACADEMIC HISTORY****RELEVANT INFORMATION: EG: THERAPIES / INTERVENTIONS / MEDICAL HISTORY**

Please indicate if any of the following professionals have been consulted. If so, please provide their name and contact details, the reason and duration for therapy. Please also include the most recent report from these professionals.

Professional	Contact Name and Number	Reason	Duration of Therapy
Paediatrician			
Physiotherapist			
Occupational Therapist			
Speech Therapist			
Audiologist			
Psychologist			
Counsellor			
Optometrist			
Remedial Teacher			
Other (please specify):			

**MEDICAL HISTORY**

Does your child suffer from any medical conditions that would have an impact on their daily lives at school? E.g.: asthma, nut allergies, epilepsy, diabetes, etc. Please supply details.

Is your child on any regular medication?

Medication	Reason	Dosage

## **SCHOOL FEE RESPONSIBILITIES**

In order to provide quality education at Fish Hoek Primary School, it is the responsibility of every parent to pay school fees.

**In the case of non-payment, parents will be asked to remove the child from FHPS and action will be taken against both parents regardless of any maintenance agreements that may exist between parties. Parents will be held liable for any legal costs that arise out of such actions. The school may record failure to meet school fee obligations with a credit information bureau. This information will be available to other credit grantors and used in making credit risk management related decisions.**

School fees are adjusted annually at the A.G.M. School fees are payable in advance.

**WE WILL BE ABLE TO PAY THE SCHOOL FEES. PAYMENT WILL BE BY:**

DEBIT ORDER	<input type="checkbox"/>
CHEQUE / CASH	<input type="checkbox"/>
MONTHLY IN ADVANCE	<input type="checkbox"/>
TERMLY IN ADVANCE	<input type="checkbox"/>
EFT PAYMENTS	<input type="checkbox"/>

*CARD FACILITIES AVAILABLE AT THE SCHOOL*

**WE, THE UNDERSIGNED, UNDERSTAND THAT IT IS OUR RESPONSIBILITY TO COVER THE SCHOOL FEES OF THIS CHILD'S TUITION. WE CONSENT TO FHPS REQUESTING CREDIT INFORMATION FROM ANY CREDIT BUREAU. WE FURTHER UNDERSTAND THAT WE WILL BE LIABLE FOR ANY LEGAL COSTS INCURRED SHOULD NON-PAYMENT OCCUR.**

SIGNED:	SIGNED:
FULL NAME:	FULL NAME:
RELATIONSHIP TO CHILD:	RELATIONSHIP TO CHILD:

**BOTH SIGNATURES ARE REQUIRED**