POTENTIAL TAKING FLIGHT
Chrysalis
SCHOOL & DEVELOPMENTAL CENTRE

343 Elizabeth Grove South, Lynnwood, Pretoria, 0081
chrysalis.preschool@gmail.com
012 348 8087

ADMISSION FORM

PERSONAL DETAILS

Date Of Application: _____ **Date Of Admission:** _____

Child's Full Name And Surname: _____

Nickname: _____ **Date Of Birth:** _____

Age at Admission: _____

Parents' Names: _____

Postal Address: _____ **Physical Address:** _____

_____ _____

_____ _____

E-Mail: _____

Medical Aid: _____ **No.:** _____

Main Member: _____

Parents' Marital Status: Single Married Divorced Widow/Widower

MOTHER	**FATHER**
Occupation:	Occupation:
Cell:	Cell:
Tel Home:	Tel Home:
Tel Work:	Tel Work:
Emergency Tel No:	

FOUNDERS · JOHANNITER HILFSWERK · STIGTERS
Fundraising No: 097-095-NPO

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Number Of Children In The Family: (Boy / girl, age) _____

_____

_____

Alternative Contact Person:

Name: _____

Relationship To Parent: _____

Tel: _____

Home Language:

AFRIKAANS	ENGLISH	SOTHO	ZULU	OTHER:

BACKGROUND INFORMATION

Child's Medical Diagnoses: _____

_____

(Please attach all medical reports)

Allergies: _____

_____

Current Medication: _____

_____

Prostheses: Hearing aid: _____ **Glasses:** _____ **Other:** _____

Special Seating Or Other Equipment: _____

Vision: _____

Low Vision Aids: _____

Referring Doctor: _____ **Tel:** _____

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Family Practitioner: _____ **Tel:** _____

Paediatrician: _____ **Tel:** _____

When did you notice your child's problem for the first time? _____

_____

Previous or current therapy that child is receiving or has received: (Please attach all reports)

_____

_____

List Any Serious Illness and Operations:

Date: _____ Illness / operation: _____

Date: _____ Illness / operation: _____

Date: _____ Illness / operation: _____

MEDICAL AND DEVELOPMENTAL HISTORY:

Duration of Pregnancy: _____ weeks

Birth Weight: _____kg

Apgar Score: _____

Neonatal Intensive Care Unit: Y/N **If Yes, Length Of Stay:** _____

Phototherapy: Y/N

Incubator: Y/N

Feeding Difficulties Experienced E.G. Poor Suck, Reflux, Nasogastric Tube Feeding: _____

Did your child make use of a pacifier? Y/N

Did or does your child suck his/her thumb? Y/N

List any problems during pregnancy (including any medication received), birth or first months of life:

_____

_____

_____

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Developmental Milestones:

Smiling: _____

Rolling: _____

Sitting: _____

Creeping/Crawling: _____

Walking: _____

Running: _____

Did your child like to lie on his/her abdomen/tummy? Y/N

Does your child display any of the following?

Temper Outbursts: _____

Rocking: _____

Head Banging: _____

FEEDING AND SLEEPING ROUTINE:

Was you child breast or formula fed, or a combination? _____

When did your child start solids? _____

Is your child a fussy eater? If yes, please specify: _____

Is your child able to feed him or herself? Y/N, please specify: _____

Which utensils does your child eat with e.g. finger feeding, spoon, knife and fork etc:

_____

Describe your child's sleeping routine i.e. does he/she awaken frequently, struggle to fall asleep, sleep right through the night, naps during the day and duration of nap time etc.

_____

_____

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SENSORY HISTORY:

Does your child avoid balancing activities, or when his/her feet are raised off the floor? Y/N

Does your child show any discomfort when having their face washed, hair brushed, during bathing, shampooing or drying? Y/N, please specify: _____

Does your child avoid certain textures of food? Y/N

Does your child seek out, or prefer fast moving, spinning or boisterous activities?

Y/N, please specify: _____

Does your child show discomfort when wearing certain textures of clothing?

Y/N, please specify: _____

Is your child a messy eater? Y/N

Does your child have difficulty with fine motor activities such as fastening clothing, or manipulating utensils etc? Y/N

Does your child tire easily? Y/N

Does your child slouch in his chair, lean against tables, walls etc? Y/N

Describe your child's disability in your own words:

_____

_____

How do you feel about your child's condition?

_____

_____

_____

How much support do you get from family and friends?

_____

_____

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Is there any other information that you want to share with us, to help us care better for your child?

_____

_____

_____

_____

_____

ROAD TO HEALTH CARD:

Please attach a copy for our records and ask us to update the card regularly.

All children must be fully immunised according to the routine clinic schedule in order to protect your child, the other children and staff.

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PRESCHOOL INFORMATION FORM

My child will attend school from Monday to Friday:

He/she will be brought at _____ by _____.

He/she will be fetched at _____ by _____.

He/she will be attending aftercare: Y/N

Please notify the staff in writing if somebody else will be fetching your child.

TOILET TRAINING:

Is your child fully toilet trained? Y/N

If not, is you child in the process of being toilet trained? Y/N

If yes, do you have specific requirements that you want the school to follow to assist with the toilet training?

_____

_____

Is your child using nappies? If yes, do you have specific requirements that you want the school to follow relating to changing nappies? _____

_____

FEEDING:

Is your child using

- A cup? Y/N
- A mug with spout? Y/N
- A baby bottle? Y/N

Is your child using a pacifier? Y/N

Does your child need assistance with feeding? Y/N

Is your child self-feeding? Y/N

If yes, is your child using utensils or only eating finger foods? _____

_____

_____

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Is there any additional information of importance about your child that the school needs to know?

_____

_____

_____

I/we _____, as parents/guardian of _____

_____, hereby confirm that all the information provided is correct.

_____ _____

Parent Signature **Date**