Lil Angels Daycare and Aftercare Centre
Daycare: 44 South Road, Tableview, 7441
Tel: 021 556 2121 Fax: 021 556 2121
Aftercare: 23 Fairway Road, Tableview, 7441
Tel: 021 556 2452 CELL: 084 656 0437

Email: info@lilangelsdaycare.co.za
Website: www.lilangelsdaycare.co.za

APPLICATION FORM

Admission Date: _____/_____/_____ Registration No _____

APPLICATION FOR THE FOLLOWING (TICK WHERE APPROPRIATE):

DESCRIPTION	HOURS OF CARE	INCLUSION	PRICE	
PRE-PRIMARY:				
Full Day:	06h30 – 18h00 Mondays – Fridays (excluding public holidays)		R3600.00	
Three quarter day:	08h00 – 14h30 Mondays – Fridays (excluding public holidays)	Includes breakfast, cooked lunch and afternoon snack	R3200.00	
Half day:	08h00 – 12h30 Mondays – Fridays (excluding public holidays)	Includes breakfast, cooked lunch	R3000.00	
Aftercare:	6h30 – 7h30 (optional) 12h45 -18h00 Mondays – Fridays (excluding public holidays)	*Includes cooked lunch and a snack, taking and dropping children at school is optional*	R1900.00	
Swimming lessons per term	(3 Months –Summer months October - April		R750.00	

10% discount is allowed for 2 or more Children – this discount applies to all children from the same household.

A non-refundable application fee of R600.00 shall be paid on date of application of registration of the child at Lil Angels.

PARENT INFORMATION

MOTHER OR GUARDIAN'S details:

NAME and SURNAME: _____

HOME ADDRESS: _____

DOMICILIUM CITANDI ET EXECUTANDI ADDRESS: _____

IDENTITY NUMBER: _____

CELL NUMBER: _____

MARITAL STATUS: _____ RELIGION: _____

OCCUPATION: _____

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

E-MAIL: _____

WORK CONTACT: _____

**NOTE: A COPY OF IDENTITY DOCUMENT AND PROOF OF RESIDENCE MUST BE DELIVERED WITH THIS APPLICATION*

FATHER OR GUARDIAN'S details:

NAME and SURNAME: _____

HOME ADDRESS: _____

DOMICILIUM CITANDI ET EXECUTANDI ADDRESS: _____

IDENTITY NUMBER: _____

CELL NUMBER: _____

MARITAL STATUS: _____ RELIGION: _____

OCCUPATION: _____

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

E-MAIL: _____

WORK CONTACT: _____

**NOTE: A COPY OF IDENTITY DOCUMENT AND PROOF OF RESIDENCE MUST BE DELIVERED WITH THIS APPLICATION*

THE CHILD'S INFORMATION:

DATE OF BIRTH: _____/_____/_____

SURNAME: _____ FULL NAME: _____

HOME LANGUAGE: _____ HOME PHONE NO: _____

HOME ADDRESS: _____

_____

NUMBER OF CHILDREN IN THE HOUSEHOLD: _____ AGES: _____

NAME OF PRIMARY CAREGIVER: _____

ARE YOU BIOLOGICAL PARENTS OF THE CHILD: _____

NAMES OF PREVIOUS DAYCARE CENTRES YOUR CHILD ATTENDED

_____City: _____ Tel: _____

_____City: _____ Tel: _____

** NOTE: A COPY OF THE CHILD'S BIRTH CERTIFICATE MUST BE DELIVERED WITH THIS APPLICATION*

HEALTH QUESTIONAIRE

* A COPY OF YOUR CHILD'S IMMUNISATION RECORDS MUST BE PROVIDED

UNDERLINE THE ILLNESSES OR DISEASES YOUR CHILD HAS OR HAD:

Chicken Pox | Diphtheria | Typhoid | Measles | Mumps | Scarlet Fever | Whooping Cough | Convulsions | Epileptic Fits | Hepatitis B | TB | HIV-Positive | Aids | German Measles

NAME ANY OTHER ILLNESSES NOT MENTIONED: _____

IS YOUR CHILD PRESENTLY ON ANY MEDICATION? _____

DOES YOUR CHILD HAVE ANY ALLERGIES? _____ DOES YOUR CHILD HAVE ANY PROBLEMS WITH?

HEARING _____ SIGHT _____ SPEECH _____

IS YOUR CHILD TOILET TRAINED (2 – 3 yrs)? _____

DOES YOUR CHILD WET HIS/HER BED REGULARLY? _____

WHAT TIME DOES YOUR CHILD GO TO BED? _____
DOES YOUR CHILD SHOW ANY SIGNS OF NERVOUSNESS? _____
HAS YOUR CHILD EVER BEEN REFERRED TO AN:

Occupational Therapist | Speech Therapist |Psychologist

If yes, please give the reasons.

_____

_____

DOES YOUR CHILD HAVE ONE OR MORE HEALTH CONDITIONS(S) THAT WILL REQUIRE SUPPORT FROM LIL ANGELS? _____

IS THERE ANY OTHER INFORMATION PERTAINING YOUR CHILD'S PSYCHOLOGICAL / PHYSICAL WELLBEING YOU WOULD LIKE TO DISCLOSE?

_____

_____

_____

FAMILY DOCTOR'S NAME & CONTACT: _____
NAME OF MEDICAL AID: _____
MEDICAL AID NUMBER: _____
DO WE HAVE YOUR PERMISSION TO SEEK MEDICAL ATTENTION FROM THE ABOVE DOCTOR IN THE CASE OF AN EMERGENCY?
YES ☐ NO ☐

SHOULD THE ABOVE DOCTOR NOT BE AVAILABLE, DO WE HAVE YOUR PERMISSION TO SEEK MEDICAL ATTENTION FROM THE CLOSEST MEDICAL CENTRE / DOCTOR IN THE CASE OF AN EMERGENCY?
YES ☐ NO ☐

DO YOU HAVE AMBULANCE COVER: _____
* in event of medical emergency requiring the use of an ambulance, the parents / carers shall be liable for the cost thereof.

ESSENTIAL INFORMATION ABOUT CHILD TO BE AWARE OF IN EVENT OF EMERGENCY, E.G. ALLERGY TO PENICILLIN: _____

**NOTE: A COPY OF THE MEDICAL PLAN CARD / CERTIFICATE OF MEMBERSHIP MUST BE PROVIDED WITH THIS APPLICATION*
ANY CHANGE IN THE CHILD'S HEALTH CARE INFORMATION MUST BE COMMUNICATED TO LIL ANGELS AS SOON AS POSSIBLE.

PEOPLE TO CONTACT IN AN EMERGENCY

1. NAME: _____ SURNAME: _____Relationship: _____

   Cell: _____ Work telephone number: _____

2. NAME: _____ SURNAME: _____Relationship: _____

   Cell: _____ Work telephone number: _____

3. NAME: _____ SURNAME: _____Relationship: _____

   Cell: _____ Work telephone number: _____

4. NAME: _____ SURNAME: _____Relationship: _____

   Cell: _____ Work telephone number: _____

PERMISSION TO HAVE YOUR CHILD COLLECTED BY A THIRD PARTY

NAME & SURNAME: _____ Relationship: _____ Tel: _____

SPECIAL NOTICE: _____

CHECKLIST OF DOCUMENTATION TO BE PROVIDED WITH THIS APPLICATION:

1. MOTHER'S IDENTITY DOCUMENT
2. MOTHER'S PROOF OF RESIDENCE
3. FATHER'S IDENTITY DOCUMENT
4. FATHER'S PROOF OF RESIDENCE
5. CHILD'S BIRTH CERTIFICATE
6. CHILD'S IMMUNIZATION RECORD
7. COPY OF MEDICAL AID CARD / CERTIFICATE OF MEMBERSHIP
8. PROOF OF PAYMENT OF NON-REFUNDABLE DEPOSIT OF R600.00

To the best of my knowledge the abovementioned information is accurate and correct.

Mother / Guardian Signature: _____ Date: _____/_____/_____

Place: _____

Father / Guardian Signature: _____ Date: _____/_____/_____

Place: _____