



Address: 72 Main Road, Howick, 3290
Telephone: +27 (033) 330 3456
Facsimile: +27 (086) 516 3159
Email: admin@oasisprep.co.za

APPLICATION FORM

Please return the Application Form with the following:

1. Birth Certificate
2. Copy of inoculation certificate
3. Copies of previous School Report (s)
4. Pastoral Reference Form
5. Copy of parent ID's
6. Latest 3 Months Bank Statements

Please place a photo of the applicant here

1. PUPIL INFORMATION

SURNAME: _____

FIRST NAMES: _____

DATE OF BIRTH: _____ MALE/FEMALE: _____

NATIONALITY: _____ HOME LANGUAGE: _____

RESIDENTIAL ADDRESS: _____

POSTAL ADDRESS (for Correspondence): _____

APPLIED FOR GRADE: _____ AGE: _____

EMERGENCY CONTACT DETAILS (Should parents not be available):

Name: _____

Relationship to Applicant: _____

Telephone Number: _____ Cell Number: _____

Health Particulars of Child: _____

Family Doctor: _____

Doctors Contact Number: _____

Blood Group: _____

Allergies: _____

	YES	NO
Do you have any physical conditions that may hinder your participation at School?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently on any medication or presently under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been hospitalized within the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently experience or have you had a history of mental or physical illness?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of the above, please provide details. _____

If you have listed a medical condition please outline how you feel this will affect your day to day living and school life. _____

SIBLINGS: (Names and ages of other children in your family)

1. _____

2. _____

3. _____

2. SCHOLASTIC INFORMATION

Name of School that your child is presently attending: _____

Name of Principal of School that your child is presently attending: _____

School Telephone Number: _____

School Email Address: _____

Has your child had any therapy in:

Remedial Work

Speech Therapy

Occupational Therapy

Does your child have any learning and/or behavioural difficulties (If so, please specify on separate page along with any records your child may have in this regard. Attach these to your application form):

3. DETAILS OF FATHER / GUARDIAN

SURNAME: _____

FIRST NAMES: _____

HOME TEL: _____ WORK TEL: _____

CELL NO: _____ OCCUPATION: _____

EMAIL ADDRESS: _____

RESIDENTIAL ADDRESS: _____

POSTAL ADDRESS (for Correspondence): _____

4. DETAILS OF MOTHER / GUARDIAN

SURNAME: _____

FIRST NAMES: _____

HOME TEL: _____ WORK TEL: _____

CELL NO: _____ OCCUPATION: _____

EMAIL ADDRESS: _____

RESIDENTIAL ADDRESS: _____

POSTAL ADDRESS (for Correspondence): _____

5. DETAILS OF PERSON RESPONSIBLE FOR PAYING THE ACCOUNT

SURNAME: _____

FIRST NAMES: _____

HOME TEL: _____ WORK TEL: _____

CELL NO: _____ OCCUPATION: _____

EMAIL ADDRESS: _____

RESIDENTIAL ADDRESS: _____

POSTAL ADDRESS (for Correspondence): _____

6. MARITAL STATUS

- | | |
|-----------|--------------------------|
| Married | <input type="checkbox"/> |
| Divorced | <input type="checkbox"/> |
| Separated | <input type="checkbox"/> |
| Widowed | <input type="checkbox"/> |

If divorced/separated, with whom does the child live? _____

7. CHRISTIAN LIFE DETAILS OF PARENTS

(a) Father

Date of Salvation ___/___/___ Water Baptism: ___/___/___ Baptism of the Spirit: ___/___/___
(dd/mm/yy) (dd/mm/yy) dd/mm/yy

Your Present Church: _____

Pastor's/ Minister's name: _____

Present Church Address: _____

Present Church Telephone: (___) _____ Email: _____

How long have you been actively involved in this church? _____

How would you describe your Christian walk? _____

(b) Mother

Date of Salvation ___/___/___ Water Baptism: ___/___/___ Baptism of the Spirit: ___/___/___
(dd/mm/yy) (dd/mm/yy) dd/mm/yy

Your Present Church: _____

Pastor's/ Minister's name: _____

Present Church Address: _____

Present Church Telephone: (___) _____ Email: _____

How long have you been actively involved in this church? _____

How would you describe your Christian walk? _____

(c) Child

Date of Salvation ___/___/___ Water Baptism: ___/___/___ Baptism of the Spirit: ___/___/___
(dd/mm/yy) (dd/mm/yy) dd/mm/yy

Your Present Church: _____

Pastor's/ Minister's name: _____

Present Church Address: _____

Present Church Telephone: (___) _____ Email: _____

How long have you been actively involved in this church? _____

How would you describe your child's Christian walk? _____

PASTORAL REFERENCE:

In order for us to make an intelligent selection of students and to help them adequately, we must learn as much as possible about them (and their families) before they come to us.

Please ensure that you help us to do this by giving the attached PASTORAL REFERENCE FORM to your church leader to fill out.

