SWAKOPMUND CHRISTIAN ACADEMY CC/99/1262

Train up a child in the way that he should go;
And when he is old he will not depart from it. (Prov 22:6)

Son Shine Kids Pre-School
Play, Learn & Grow Together for His Glory

PRE-PRIMARY SCHOOL APPLICATION

APPLICANT NAME: _____

APPLICATION DATE: ____ / _____ / _____

Please note that final acceptance of the applicant is subject to: -

- ***An interview with the parents and child (if necessary)***
- ***Attendance at Parent Orientation Programme***

Please submit the following copies with the application: -

- ***Immunisation Record***
- ***Most recent Progress Report from current school***

OFFICE USE ONLY:

Application Received:	___ / ___ / _____
Diagnostic Test Date:	___ / ___ / _____
Interviewed By:	_____
	_____
Interview Date:	___ / ___ / _____
Date Accepted:	___ / ___ / _____

P.O. Box 1777, Swakopmund
137 Anton Lubowski Str.
Tel: 404605 / **Fax**: 400144
e-mail: school.office@swakopca.com
website: www.swakopca.com

GENERAL INFORMATION

Applicant Surname:		**Name/s:**	
Name to use at school:		**Gender:**	**M / F**
ID #:		**Citizenship:**	
Study Permit:		**Birth date:**	
Left/Right Hand Preference:	**L / R**	**Age:**	
Favourite Colour:		**Favourite Animal:**	
Favourite TV Programmes & Computer Games:		**Hours a week @ TV, video, computer games:**	
How many friends does your child have?		**Does your child interact easily with adults?**	
Favourite physical activity/sport:			
Favourite unstructured or free-play time:			
Who does your child like the most & why?			
Does your child participate in any extra-mural activities? Which?			
What discipline methods do you use with your child?			
Tell me about your child in a few sentences…			
Have any traumatic, stressful or unusual circumstances occurred in your child's life that you feel we should be aware of?			

FAMILY INFORMATION

Father's Surname:		**Name/s:**	
Employer:			
Occupation:			
Normal working hours:			
Specialist skills/hobbies:			
Telephone (W):		**Fax #:**	
Telephone (H):		**Cell Phone:**	
E-mail Address:		**Marital Status:**	

Mother's Surname:		**Name/s:**	
Employer:			
Occupation:			
Normal working hours:			
Specialist skills/hobbies:			
Telephone (W):		**Fax #:**	
Telephone (H):		**Cell Phone:**	
E-mail Address:		**Marital Status:**	

Postal Address for School use: -

RELIGIOUS INFORMATION

Current Church:					
Address:					
Pastor:			**Tel #:**		
Is Father a Christian?	**YES** Date: __ / __ / ___	**NO**	**Is Mother a Christian?**	**YES** Date: __ / __ / ___	**NO**
Has Your child made a profession of faith in Jesus Christ?				**YES -:** __ / __ / ___	**NO**

SCHOLASTIC INFORMATION

Last School Attended:				
School Address:				
What was the attitude of your child's last teacher towards him/her?				
Has your child ever been expelled, suspended or refused admission at another school?				
If "Yes", give details:				
Has/does your child experience difficulties making friends or socialising?				
Explain:				
Has your child ever been referred for any specialist evaluation for academic or other difficulties/conditions?				
Explain:				
Has your child ever had any severe disciplinary difficulties at home or school?				
Explain:				
Indicate academic level of your child's previous work:	**Excellent**	**Good**	**Average**	**Poor**
How would you rate your child's academic ability?	**Above Average**	**Average**	**Below Average**	**Irrelevant to me**

How did you hear about this Pre-School?	
What do you hope this Pre-School will 'do' for you and your child?	
What type of teacher and school environment would be best for your child?	

MEDICAL INFORMATION

Family Doctor:		**Tel #:**	

PAST CONDITION: (If your child has contracted any of the following, state age)

Mumps		Diphtheria		Polio	
Measles		Scarlet Fever		Convulsions	
Whooping Cough		Rheumatic Fever		Heart Disease	
Asthma		Chicken Pox		Diabetes	
Known allergy		Pneumonia		Recurrent Ear Infections	
STD e.g. syphilis/ Gonorrhoea		Tuberculosis		HIV/AIDS	
Diagnosed ADD/Hyperactive		Hyperglycaemia		Other:	

RECENT CONDITION: (Please check any one of the following noted recently)

4 or more colds annually		Fainting spells		Hearing difficulty	
Frequent sore throat		Abdominal pains		Tires easily	
Poor vision		Frequent urination		Breath shortness	
Dizziness		Allergy		Hernia	
Frequent sties		Persistent cough		Ring worm	
Dental defects		Speech difficulty		Nose bleeding	
Crippling condition		Mood swings			

MEDICAL TESTING: Please answer all of the following.

General hearing test	Yes	No	Date: ___ / ____ / _____	
General eye/vision test	Yes	No	Date: ___ / ____ / _____	
Tuberculosis	Yes	No	Date: ___ / ____ / _____	
HIV/AIDS	Yes	No	Date: ___ / ____ / _____	

PERSONAL HISTORY: Please answer all of the following.

Is he/she shy?		Overactive?		Bite fingernails?	
Suck thumb?		Have excessive fears?		Regular temper tantrums?	
Like school?		Play well with others?		Eat breakfast regularly?	

When is his/her usual bedtime?		**When is his/he usual rising time?**	

Does your child have a disability due to disease or an accident? If "Yes", please specify.

Is your child currently on any chronic or other form of medication? If "Yes", please specify.