



ADMISSION FORM

Child's Name: _____

Gender: _____ Date of birth: _____

Address: _____

Postal Address: _____

Mothers Name: _____ Cell: _____

Fathers Name: _____ Cell: _____

Mothers Occupation: _____ Phone No: _____

Fathers Occupation: _____ Phone No: _____

Emergency contact: _____ Cell: _____

Relationship to the child: _____

(In case if an emergency another contact person other than the parent is required)

Doctors Name: _____ Phone No: _____

Allergies/Dietary Requirements: _____

BEEHIVE MONTESSORI PRESCHOOL

16 Haygarth Road, Kloof

Tel: 031-7641613

E-mail: info@beehivepreschool.co.za

Website: www.beehivepreschool.co.za



Health Requirements (Include relevant medical history):

EMERGENCY TREATMENT:

In the event of an emergency, accident or illness, I consent to my child receiving any necessary medical treatment.

Signed: _____

Date: _____

May we administer:

- Ponstan
- Panado
- Rescue Remedy

(Please initial next to the medication you would prefer)

OTHER INFORMATION:

Background information on your child that may help us to understand him/her. E.g.: Any brothers or sisters, recent events that have affected you child, toileting issues, comforters, special words etc.

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