Glenoaks General Information Form

Date form completed: ______________________

CHILD'S PERSONAL DETAILS	
Surname:	Name:
Date of birth:	Age:
Grade:	Teacher's name:

BIOLOGICAL MOTHER'S PERSONAL DETAILS	BIOLOGICAL FATHER'S PERSONAL DETAILS
Surname: Title:	Surname: Title:
First name:	First name:
Marital status:	Marital status:
Home phone No.:	Home phone No.:
Work phone No.:	Work phone No.:
Cell phone No.:	Cell phone No.:
E-mail address:	E-mail address:
Residential address:	Residential address:
Occupation:	Occupation:
Job Title:	Job Title:
Employer:	Employer:
Employer address:	Employer address:

STEP MOTHER /GUARDIAN'S PERSONAL DETAILS	STEP FATHER / GUARDIAN'S PERSONAL DETAILS
Surname: Title:	Surname: Title:
First name:	First name:
Guardian or Step Mother:	Guardian or Step Father:
Marital status:	Marital status:
Home phone No.:	Home phone No.:
Work phone No.:	Work phone No.:
Cell phone No.:	Cell phone No.:
E-mail address:	E-mail address:
Residential address:	Residential address:
Occupation:	Occupation:
Job Title:	Job Title:
Employer:	Employer:
Employer address:	Employer address:

RELATIVE OR FRIEND OF THE FAMILY IN CASE OF AN EMERGENCY (**Someone other** than the child's parent)		
Surname:	Title:	First name:
Contact number.:		Relation to the child (e.g. Grandparent):

MEDICAL AID DETAILS IN CASE OF EMERGENCY	
Name of medical aid:	Membership number:
Main member:	Identity number:

MEDICAL HISTORY	
Does your child suffer from allergies? Yes / No **(Please circle the applicable answer)** If yes, please state the nature of the allergy (e.g. Allergy to bees, peanuts, etc):	
Do they require any medication regarding the allergy? Yes / No **(Please circle the applicable answer)** If yes, please specify (e.g. Epi pen, etc):	
Does your child wear glasses? Yes / No	Does your child have a hearing aid? Yes /No
Comment on above:	
Please state any other medical conditions that the school should be aware of: (e.g. seizures etc.):	

MEDICATION		
Does your child take any medication (e.g. Ritalin for concentration etc.?): Yes / No		
Name of medication:	**Dosage:**	**Time / s to be administered:**
Doctor's Name:	Contact Number:	

FAMILY DYMANICS					
With whom does child currently live? **Please tick the relevant block / blocks**					
Biological Mother		Biological Father		Mother's Partner / Fiancé	
Father's Partner / Fiancé		Step Mother		Step Father	
Guardian		Grand mother		Grand father	
Other: **(Please specify)**					

SIBLINGS					
Brother/s Name and age	**Step-Brother/s name and age**	**Do they live in the same house?**	**Sister/s Name and age**	**Step-sister/s name and age**	**Do they live in the same house?**

Please indicate any recent changes in the family (e.g. Separation, divorce, death in the family, change of living arrangements, new step parents / siblings etc.)

Is there anyone in the child's immediate family with which he has no contact / very little contact /is not allowed contact? ie. A parent / grandparent. Please specify who and brief reason:

If divorced or separated, would you like two reports to be issued at the end of each term? Yes /No

Does your child attend an aftercare/homework group, etc? Yes / No If yes, please state the name of the aftercare facility, homework group or au pair/ tutor:

Other/comments:

Thank you for your assistance in completing this this form. Please note that this information will be updated on an annual basis. Should any information like Cell phone numbers, parent / sibling changes, change of address or emergency contact details change at any stage in the year, please feel free to contact the school and give the updated information, as this may be vital in contacting you in an emergency.