P.O. Box 11050,

Selcourt, SPRINGS 1567

E-mail: stcaths@stcaths.co.za

30 Wankie Avenue,

Selcourt, SPRINGS 1559

Phone: 011 818-1126

CHILD'S DETAILS:

Surname: ....

First names: ....

Home Language: ....

Known as: ....

If not English, do you the parent's under-take to speak and read to your child in English.
Yes / No

Child - L/R handed

Father - L/R handed

Mother - L/R handed

Date of birth: ....

Names and ages of brothers:

....

....

Names and ages of sisters:

....

....

PARENT/GUARDIAN INFORMATION:

FATHER:

Surname: ....

Name: ....

Occupation: ....

I.D. No: ....

Tel: Home: ....

Work: ....

Cell: ....

E-mail: ....

Address: ....

.... Code ....

Postal address: ....

.... Code ....

Medical aid: ....

Member's name: ....

Medical aid plan: ....

Medical aid no: ....

MOTHER:

Surname: ....

Name: ....

Occupation: ....

I.D. No: ....

Tel: Home: ....

Work: ....

Cell: ....

E-mail: ....

Address: ....

.... Code ....

Postal address: ....

.... Code ....

Emergency contact numbers:

Name: ....
Cell no: ....

Name: ....
Cell no: ....

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PREGNANCY & BIRTH HISTORY:

Any problems during pregnancy? YES / NO

Any complications at birth? If so, elaborate

…………………………………………………………

…………………………………………………………

…………………………………………………………

…………………………………………………………

MEDICAL HISTORY:

Copy of your child's:
Health card YES / NO
Birth certificate YES / NO

Has your child suffered from any of the following?
Tonsillitis YES / NO
Sinusitis YES / NO
Asthma YES / NO
Eczema YES / NO

Ear infections YES / NO
(seldom/frequently)
…………………………………………………………
Grommets? ……………………………………………
Number of times ………………………………

Allergies: …………………………………………………
…………………………………………………………
…………………………………………………………
Head injuries: ………………………………………
…………………………………………………………
…………………………………………………………
Operations: ……………………………………………
…………………………………………………………
Fever convulsions / normal convulsions:
…………………………………………………………
…………………………………………………………
Periods of unconsciousness:
…………………………………………………………
Hospitalisation:
…………………………………………………………
Other injuries / illnesses:
…………………………………………………………

Has your child been seen by any Specialist? E.g. heart, occupational therapist, speech therapist, neurologist.

Name	Date	Findings

(Please provide copies of the above related reports.

ACTIVITIES OF DAILY LIVING:

Independent in toilet usage? YES / NO
Able to wipe own bottom? YES / NO
Independent in dressing? YES / NO

EMOTIONAL DEVELOPMENT:

Specific emotional trauma – death of a family member, hijacking, burglary, car accident, marriage problems, house move etc.

…………………………………………………………
…………………………………………………………
…………………………………………………………
…………………………………………………………
…………………………………………………………

GENETIC/FAMILY HISTORY:

Any of the following problems in the family history (not only mom and dad, but parents' siblings, their children etc.

Epilepsy? YES / NO

ADD/ADHD? YES / NO

Learning difficulties? YES / NO

Dyslexia? YES / NO

Migraines? YES / NO

Vision difficulties? YES / NO

Hearing difficulties? YES / NO