




7 Pollard Street Lorraine
Port Elizabeth
6070

Jaslyn  064 592 1696

 enquiries@littlekidoaks.co.za

PLEASE TICK AS WE ALLOW 11 MONTHS only!!

Kindly read all fee structure, notice period as well as the breaching of clause policy!!!

KINDLY TICK YOUR OPTION PAYMENT PLAN!! If there are any change of payment plans, kindly let me know to amend it to your needs, however, give me 30 days' notice and kindly read all terms and conditions.

11 MONTHS PLAN

Both parents name and surname and I.D number that you have read all our terms and conditions

CHILD:	FIRST NAME:	SURNAME:
GENDER: M / F		
RACE and RELIGION		
DATE OF BIRTH:		
RESIDENTIAL ADDRESS:		
MOTHER:	FIRST NAME:	SURNAME:
CONTACT NUMBER		
PLACE OF EMPLOYMENT:		
OCCUPATION:		
TELEPHONE:		
FATHER:	FIRST NAME	SURNAME
CONTACT NUMBER		
PLACE OF EMPLOYMENT:		

Initials

Little Kid-Oaks Playschool and Aftercare

OCCUPATION:			
TELEPHONE:			
MEDICAL AID DETAILS:	MEDICAL AID SCHEME:		
	MEDICAL AID NUMBER:		
RELATIONSHIP STATUS OF PARENTS	MARRIED/ SINGLE PARENT/ DIVORCED/ LIVING TOGETHER/WIDOWED		
IS YOUR CHILD ALLOWED ON OUR SOCIAL MEDIA PLATFORMS?	YES / NO		
OR ONLY FACEBOOK PAGE?	YES / NO		
CONTACT PERSON IF PARENTS CANNOT BE CONTACTED"	NAME	CONTACT NUMBER	RELATIONSHIP

E-MAIL ADDRESS:	MOTHER	FATHER	
WE ARE KEEN TO KNOW WHERE YOU HEARD ABOUT OUR SCHOOL	FACEBOOK	WEB	OTHER: Please state

Which date would you like your child to start at Little Kid-Oaks? _____

Age group class: _____

Who will bring the child to school? _____

Who is allowed to fetch the child from school? _____

Is he/she allergic to anything? _____

Does the child suffer from any of the following ailments? If "YES" please state

1. Asthma _____ 2. Epileptic fits _____ 3. Heart Disease _____ 4. Allergies _____
5. Other _____

If YES, please indicate which condition, whether mild, moderate, severe and whether or not they are on medication for the said condition and which medication(s) they are on.

I have completed the above to the best of my knowledge and hereby declare that my child has no other pre-existing conditions that I am currently aware of.

Parent name: _____ Signature _____

Is the child up to date with he/she immunisations? _____ Please provide photocopies of the immunisation section. **N.B. DO NOT SEND THE CLINIC CARD; WE WILL NOT BE LIABLE IF ITS LOST! BUT PLEASE SEND COPIES OF THE LEARNER CLINIC BOOK, BIRTH CERTIFICATE AND BOTH PARENTS I.D TO BE SENT VIA EMAIL AT ENQUIRIES@LITTLEKIDOAKS.CO.ZA OR HAND IN THE HARD COPIES TO SCHOOL.**

N.B. Please provide copies of both parents i.d. documents.

Is the child's urination and bowel action normal? _____

Family doctor's details: Name: _____ Telephone: _____

Doctor's address: _____

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Little Kid-Oaks Playschool and Aftercare

Please be advised that we are affiliated with ECMR (East Cape Medical Response) and in the case of a medical emergency they will administer treatment on site. This is covered under the Little Kid-oaks policy. Should their paramedics feel it is necessary to call an ambulance, please note that this will be for your own account. You will be contacted in the event of a medical emergency.

In case of a medical emergency, and should the principal be unable to contact myself or the Doctor nominated by me, I consent to the Principal using her discretion and agree to hold the school indemnified for any claim which might arise as a result of this action on her part.

Signature _____ Date: _____

I hereby apply for the admission of the above child and agree to abide by the Conditions of Enrolment and Rules and Regulations of the school.

Mothers Name: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

Principal signature: _____ Date: _____

Kindly email the above form once completed to enquiries@littlekidoaks.co.za or you may hand it directly in at our school premises.

Kind Regards.



Jaslyn Hermanus
Principal & Owner

Initials