



GOOD HOPE SEMINARY HIGH SCHOOL



Tel : (021) 465-2330

30 Hope Street

Fax : (021) 461-3902

Cape Town

Hostel : (021) 465-2387

e-mail : ghshs@iafrica.com

8001

APPLICATION FOR CHARLTON HOUSE HOSTEL ADMISSION - 2020

DATE	
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PLEASE COMPLETE THE FOLLOWING AND RETURN THIS TO US WITH A COPY OF YOUR DAUGHTER'S LATEST REPORT AND BIRTH CERTIFICATE. APPLICATIONS WILL NOT BE PROCESSED WITHOUT ALL THE RELEVANT DOCUMENTATION

FULL NAME OF PUPIL			
PRESENT SCHOOL - PREVIOUS SCHOOL ATTENDED IF ANY		DATE OF BIRTH	
NO. OF CHILDREN IN FAMILY		IS THIS THE 1 st , 2 nd 3 rd CHILD ETC	
GRADE IN THIS YEAR		EXPECTED GRADE NEXT YEAR	
MOTHER'S/GUARDIAN'S FULL NAME			
OCCUPATION		I.D. NO:	
HOME ADDRESS			
P.O.BOX NO			
NAME OF EMPLOYER/COMPANY			
ADDRESS			
TEL NO (H)		TEL NO (W)	
CELL NO		FAX NO	
FATHER'S/GUARDIAN'S FULL NAME			
OCCUPATION		ID NO	
HOME ADDRESS			
P.O.BOX NO			
NAME OF EMPLOYER/COMPANY			
ADDRESS			
EMAIL ADDRESS			
TEL NO (H)		TEL NO (W)	
CELL NO		FAX NO	

INCOME TAX NUMBER			
NAME OF CONTACTABLE RELATIVE	CONTACT NO:		
I understand that completing an application form does not ensure acceptance into the school or hostel.			
Signed: _____			
FOR OFFICE USE ONLY:			
PASTEL ACCOUNT NUMBER:			
DEPOSIT DETAILS:			
ACCOUNT OPENED:			

Relevant credit checks can be done in order to approve your application



INDEMNITY FORM

Parent/Guardian's General Consent and Indemnity

I, the undersigned _____ (Full Name) of

_____ (Address)

warrant that I am the guardian of _____ (daughter's name)

I hereby consent to my daughter taking part in excursions and outings organised by **Good Hope Seminary High School**, either at the school or extramurally, while she is enrolled as a learner at the school.

I understand and accept that such activities are taken at my daughter's own risk, and I hereby, on behalf of myself, my executors, my representative and my daughter, indemnify, hold harmless and absolve **Good Hope Seminary High School** and/or the staff, and/or any organisation involved in such activities against and from any or all claims whatsoever that may arise in connection with any loss or damage to the property or injure to the person of my daughter during such activities. I acknowledge that the consent and indemnity shall be operative with effect from the time my daughter is or was enrolled at **Good Hope Seminary High School** and that this consent and indemnity should continue for as long as she is a learner at the school.

I further authorise the person in charge during such activities to act in '**Loco Parentis**' and I cede my posers as guardian to the Principal of the school or her representative in the event that medical treatment or surgery be deemed necessary for my daughter. I accept that all reasonable precautions will be taken to ensure the safety and welfare of my daughter and that I shall be held responsible for the payment of the medical and/or hospital accounts, where applicable.

Dated at _____ this _____ day of

_____ .

Signed: _____ (Mother/Father/Guardian)

Medical Aid Society: _____

Medical Aid Number: _____

Details of Main Member:

Mr/Mrs _____

Signature of Main Member: _____

GENERAL INFORMATION FORM

SURNAME OF LEARNERS: _____ GRADE: _____ (2019)

FULL NAMES OF LEARNER: _____

DATE OF BIRTH: _____ ID NO. _____

DAY SCHOLAR: yes / no BOARDER: yes / no HOME LANGUAGE: _____

ADDRESS AND PERSON'S NAME WHERE LEARNER RESIDES:

Name: _____

Relationship to Learner: _____

Address: _____

_____ Code: _____ Learner

Cellular Telephone Number: _____ Home landline No. _____

MOTHER/GUARDIAN'S DETAILS

Mrs / Ms (please circle the correct one) _____ Name and Surname

ID No. _____

Marital Status: Married / Divorced / Single

Residential Address: _____

Telephone no. H _____ W _____ Cell _____

Fax: _____ eMail: _____

Occupation: _____ Name of Company: _____

Work Address: _____

FATHER /GUARDIAN'S DETAILS

Mrs / Ms (please circle the correct one) _____ Name and Surname

ID No. _____

Marital Status: Married / Divorced / Single

Residential Address: _____

Telephone no. H _____ W _____ Cell _____

Fax: _____ eMail: _____

Occupation: _____ Name of Company: _____

Work Address: _____

NUMBER OF CHILDREN IN THE FAMILY: _____ Is this learner 1st, 2nd, 3rd _____

MEDICAL INFORMATION AND CONTACT NUMBERS:

We would like to give your daughter the best possible care at all times, especially in a medical emergency. With this in mind, please provide us with the necessary information below.

PERSON TO CONTACT WHEN YOUR CHILD IS ILL AT SCHOOL:

- 1. _____ Cell No. _____
Home No. _____ Work No. _____
- 2. _____ Cell No. _____
Home No. _____ Work No. _____

FAMILY DOCTOR'S NAME: _____

Contact numbers: _____

Address of Doctor's Practice: _____

RELEVANT MEDICAL DETAILS AND INFORMATION: (tick appropriate)

Please add in any other relevant information, such as illnesses and operations.

Penicillin allergy		Asthma	
Bee-sting allergy		Diabetes	
Other Allergies – please list below		Epilepsy	
		Other ailments – please list below	

MEDICAL AID DETAILS

NAME OF MEDICAL AID SCHEME: _____

MEDICAL AID NUMBER: _____

MAIN MEMBER'S NAME: _____

Please attach a copy of your medical aid card to this form.

In the event that any of this information changes, please inform us immediately.

I, _____ (Parent/Guardian) of _____

hereby give the Principal or her representative permission to acquire medical assistance for my daughter should she need it.

Signed: _____ Date: _____

