CARMEL SCHOOL
P.O. Box 2068
BULAWAYO

Fax : 2968421 Tel: 2969421

ENROLMENT FORM

Proposed Date of Enrolment	Month	Year	Grade
First Name of Child	Surname		
Date of Birth Day Month	Place of Birth		
Birth Certificate Number	Male	Female	Religion
Nursery School		Year	Grade
Previous Primary School		Year	Grade

Email Address Dad: ______________________________

Mum: ______________________________

Residential Address

Tel:	Cell:
Father or Guardian's Name	
Occupation	
Name of Business	Nature of Business
Business Address:______________________________	
Tel:	Cell:
Mother or Guardian's Name	
Occupation	
Name of Business	Nature of Business
Business Address:______________________________	
Tel:	Cell:

Names of Other Children in Family	Date of Birth	School	Grade

Signature of Parent/Guardian ______________________ Date: ______________

IF THERE IS NO HOME TELEPHONE NUMBER PLEASE GIVE AN ALTERNATIVE CONTACT NUMBER IN CASE OF

EMERGENCY

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PLEASE HAVE THIS FORM FILLED IN AND STAMPED BY YOUR DOCTOR OR CLINIC

Medical History

Physical Defects (if any)
Allergies
Serious illness/Injuries
Operations

Immunisation History

Immunisation		Date Given	5 Year Booster	Date Given
BCG (BIRTH)			DT	
DPT 1	Polio 1		Polio Booster	
DPT 2	Polio 2		BCG	
DPT 3	Polio 3		12 Year Booster	
DPT 4	Polio 4		BCG	
Measles			Rubella (Girls)	
Hepatitis 1				
Hepatitis 2				
Hepatitis 3				
Other				
MMR				
HIB				

Clinic / Doctor's Stamp

Doctor's Name:____

Medical Aid Society:________________________________ No:______________ Suffix:_______

Tel:___________________________________

Declaration

If my child requires urgent attention, I give full authority to the school staff to arrange for my child to be taken to the nearest hospital for treatment if this course is warranted by the degree of urgency.

Signature of Parent/Guardian:______________________ Date:_______________________