

WALVIS BAY PRIVATE SCHOOL

DEVELOPMENT HISTORY GRADE R APPLICANTS



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APPLICATION FOR YEAR		APPLICATION FOR GRADE	
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Enrollment Number		Family Code/Account Number	
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NAME OF LEARNER			
SURNAME			
CURRENT AGE	YEARS		MONTHS
GENDER	MALE		FEMALE
Home language mother uses with the applicant			
Home language father uses with the applicant			

PREVIOUS DAY CARE			
Year(s) attended the day care	FROM		TO
Language of instruction at the day care			

PREVIOUS PRE-PRIMARY			
Year(s) attended the pre-primary	FROM		TO
Language of instruction at the pre-primary			

POSITION IN FAMILY:	
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Name of Brother/Sister	Gender of Brother/Sister	Age of Brother/Sister
1.		
2.		
3.		
4.		

HISTORY OF DEVELOPMENT FROM DATE OF BIRTH:

Natural conception	YES	NO	Assistant Conception	YES	NO
BIRTH HISTORY:					
NORMAL	YES	NO	CAESAREAN	YES	NO
Phase:	Months:	Weeks:	Phase:	Months:	Weeks:

Duration of birth process: _____ Any complications: _____ Incubator: YES/NO Time in incubator: _____ Reason: _____ Assistance with breathing: YES/NO Was oxygen applicate: YES/NO	Elective Caesarean <input type="checkbox"/> Emergency Caesarean <input type="checkbox"/> If emergency caesarean, please state reason: _____ Incubator: YES/NO Time in incubator: _____ Reason: _____ Assistance with breathing: YES/NO Was oxygen applicate: YES/NO
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APGAR: 1/10	2/10
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Country in which your child was born? _____

Hospital in which your child was born? _____

Who was your child's doctor at birth? _____

Birth weight: _____

Head Circumference: _____

Length Head to Feet: _____

FEEDING HISTORY:

Breast feeding:	YES	NO	Bottle feeding:	YES	NO
From: _____			From: _____		
To: _____			To: _____		
When did Mom returned to work? _____					

HISTORY OF THE EYES:

Did your child have Jaundice?	YES	NO
Did he/she receive treatment under ultra violet rays?	YES	NO
Duration of treatment: _____		

HISTORY OF THE EARS:

Ear infection(s)?	YES	NO
Was it a recurring ear infection?	YES	NO
Was it treated successfully?	YES	NO
Any other infections? _____		
Did your doctor refer you to: Ear/Nose/Throat Specialist? _____		
Please state the specialist name: _____		

DEVELOPMENTAL HISTORY:

At what age did your child sit without support? _____

At what age did your child start to crawl? _____

How long did he/she crawl? _____

How did he/she crawl? _____

When did he/she start walking without support? _____

Did you make use of a jolly jumper? _____

Did you make use of a walking ring? _____

LANGUAGE HISTORY:

At what age did he/she start talking words? _____

Did he/she stutter and at what age? _____

Did he/she lisp and at what age? _____

When did your child start using sentences consisting of three (3) words or more? _____

LEARNER MEDICAL HISTORY:

Are there any physical disabilities, illnesses or allergies the school should be aware of?

Kindly elaborate: _____

	Condition	Medication
Allergies: (Peanuts, bee stings, etc.)		
Chronic Illnesses: (Diabetes, epilepsy, etc.)		
Medical Conditions: (Pulmonary stenosis, muscular dystrophy, cerebral palsy, etc.)		

Disabilities:

(Hard of hearing, partially sighted, autistic spectrum disorder, ADHD, etc.)

Has your child ever required remedial, occupational, and kinesthetic or physiotherapy? If YES, please supply/attach evaluations and reports: YES NO

Any childhood illness: Mumps Measles Chicken Pocks Rubella

Other Please elaborate _____

Are there any other confidential information that we must know about?

I have read and understood the content of this application form and all relevant information submitted by me is correct. I have omitted no relevant information. I further undertake to submit my child and me to the rules and regulations as set by the school's directors.

We require the signatures of both parents'/guardians'

Father: _____ (Full name & Surname) _____

Mother: _____ (Full name & Surname) _____

Date: _____