



No 14 Ambrose Street
 Sydenham
 Port Elizabeth, 6001
 Cell: 069 367 5622
 supermainman@gmail.com

THE MAIN DAYCARE ENROLLMENT FORM - 2026

Date of Enrolment	
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Student Details

Surname			
First Names			
Age			
Date of Birth			
ID Number			
Gender		Male	Female

PARENT DETAILS

	Mother	Father
Surname		
First Names		
ID Number		
Occupation		
Employer Name		
Home address		
Email		
Mobile		

EMERGENCY CONTACT DETAILS

Surname			
First Names			
ID Number			
Relationship			
Home address			
Email			
Mobile			

MEDICAL AID DETAILS

Scheme Name			
Plan			
Membership Number			
Principal Member			

MEDICAL HISTORY

Has your child ever broken a limb?	Yes	No		
Please specify (If Yes)				
Does your child take any chronic medication	Yes	No		
Please specify (If Yes)				
Has your child undergone any surgery?	Yes	No		
Please specify (If Yes)				
Are there any special medical, physical or emotional needs that your child require	Yes	No		
Please specify (If Yes)				
Last dentist visit	Date		Reason	
Last doctor visit	Date		Reason	
In the event of an emergency, may we take your child to the nearest doctor (You will be liable for costs incurred)	Yes	No		



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Has your child had any of the following illness? Please tick only if "YES"

<input type="checkbox"/>	Croup	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Eye Infection	<input type="checkbox"/>	Ear Infection
<input type="checkbox"/>	Rubella	<input type="checkbox"/>	Encephalitis	<input type="checkbox"/>	Whooping Cough
<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	Respiratory tract infection	<input type="checkbox"/>	Prone to thrush	<input type="checkbox"/>	Skin Rashes

Other, please specify _____

Does your child have any allergies or intollerences? Please tick only if "YES"

<input type="checkbox"/>	Bee stings	<input type="checkbox"/>	Peanuts	<input type="checkbox"/>	Fish
<input type="checkbox"/>	Lactose	<input type="checkbox"/>	Pet Hair	<input type="checkbox"/>	Dust
<input type="checkbox"/>	Gluten	<input type="checkbox"/>	Wheat	<input type="checkbox"/>	Sucrose
<input type="checkbox"/>	Analgesics	Please Specify _____			
<input type="checkbox"/>	Anti-biotics	Please Specify _____			
<input type="checkbox"/>	Preservatives	Please Specify _____			
<input type="checkbox"/>	Other	Please Specify _____			

BILLING INFORMATION

Person responsible for school fees	Name	
	Surname	
	Postal Adress	
	Home Adress	
	ID Number	
	Mobile Number	
	Email Adress	
Next of Kin	Name	
	Postal Adress	
	Mobile Number	

I, _____ (name), _____ (ID/Passport no.), hereby confirm that all the above information is true and correct at the time of signing this document

Signature _____ Date: _____

Documents required

1	ID/Passport document for both parents
2	Child birth certificate/passport
3	Child's clinic card
4	Copy of medical aid card

Bank Details	School Fees
Account Holder: The Main Daycare	2 Years - 5 Years - R1 250,00
Bank Name : Nedbank	03 Months - 2 Years - R1 400,00
Account Number: 1314908790	Inclusive of Breakfast and Lunch
Account Type: Current	Registration: R400,00 (non refundable)