

Kidzhub Nursery School 2026/2027

Tel: 084 321 6629
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PO Box 12788
Leraatsfontein
Witbank

Date of entrance required: _____ Date of application: _____

Child's name: _____ Surname: _____

Date of birth: _____ Age: _____

Male _____ Female _____ Religion: _____

Allergies: _____

Residential address: _____

Home language: _____

Home telephone number: _____ Cell: _____

Email address: _____

Father:

Name and Surname: _____

Tel no: _____

Occupation: _____

Name of employer: _____ Tel no: _____

Work address: _____

Mother:

Name and Surname: _____

Tel no: _____

Occupation: _____

Name of employer: _____ Tel no: _____

Work address: _____



KIDZHUB NURSERY SCHOOL

Next of kin:

Name and Surname: _____

Address home: _____

Tel no home: _____ Cell: _____

Number of children in family: _____ Ages: _____

Who will bring the child? _____ What time? _____

Who will fetch the child? _____ What time? _____

Was your child vaccinated against the following?

Polio: _____

Measles: _____

TB: _____

Whooping cough: _____

Diphtheria: _____

Name all contagious / childhood diseases he/she had:

Name of family doctor: _____ Tell no: _____

Name any other specific problems, e.g.: thumb- sucking or allergies e.g.: Penicillin, bee-
stings etc: _____

Has your child been in a nursery school before? _____

Name of school: _____

Name of town where the school is: _____

Reason for leaving the school: _____

How did you get to know about Kidz Hub Nursery school?



Parents must complete this part. This is valid for outings or any other reason to transport your child:

Permission from parents: transportation of child

- 1) I: _____ parent/guardian (full name and Surname) of: _____ (full name and surname)

Give permission that he/she may be transported by the transport the school provides.

- 2) I accept that all reasonable precautions will be taken for the child's safety and that I will be held responsible for payment of all medical or hospital expenses. In the case of an injury that was not because of the negligence of the responsible person.
- 3) I hereby authorise the principal of the school or her representatives to take a decision if any medical- or surgical treatment is necessary.
- 4) I request that the responsible person will pay attention to the following e.g.: Allergies, epilepsy, abnormal bleeding etc: _____

Medical information

Medical scheme: _____

Medical scheme number: _____

Full name and surname of principal medical aid member: _____

ID of principal medical aid member: _____

Name of employer: _____

Work address: _____

Full name and surname of child: _____

ID or birth date of child: _____

Signature of parent / guardian

Date



Information of responsible person for the payment of the account:

Full names and surname of child: _____

ID number of child: _____

Full names and surname of account holder: _____

ID number of account holder: _____

Email address of account holder: _____

Relationship between the account holder and child: _____

Postal address: _____

Physical address: _____

Work address: _____

Work contact number: _____

Tell / cell: _____

Mr / Me: _____ Signature: _____

Date: _____





