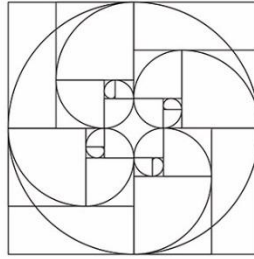


GALASA

GIFTED & ADVANCED LEARNING ACADEMY OF SOUTH AFRICA



PRELIMINARY HEALTH OF APPLICANT FORM

Please submit this form directly to GALASA via the addresses provided below, for attention Mr. D. Silman. For any queries please phone 083 554 7647.

Please scan & return to: davidsilman@galasa.org.za

STREET ADDRESS

POSTAL ADDRESS

38 Oxford Road

P.O Box 5168

Parktown

Raedene

Johannesburg

Johannesburg

2193

2124

Applicant's Name _____

List all medications prescribed for a month or more, which your child is currently taking or has taken in the past year.

Name of Medication

Dosage and Frequency

Please list all injuries, illnesses or chronic conditions which have required provision of ongoing medical treatment, long-term therapy or long term hospitalisation.

Allergies: Include information related to medications, environment, food or insects. Indicate if your child requires an Epi-pen for treatment.

Has your child's physical activity been restricted at any time in the last five years?

Has your child ever received professional counselling or therapy? If so, please give a brief explanation and provide the name and contact information of the professional consulted. This refers to psychotherapy, physiotherapy, Occupational therapy, Speech therapy and Remedial therapy.

I declare that the above-listed information is true and complete and that I have not withheld any information.

Parent/Guardian signature _____ Date _____