APPLICATION FOR ADMISSION TO WENAKKER

READ THIS FIRST

1. Please ensure that this application form is duly completed, signed and accompanied by all the required supporting documents, as missing or omitted information will delay the finalisation of application.
2. **Section C** must be completed by a registered medical doctor and it is the applicant's responsibility to have this form completed by a registered medical doctor.
3. **This application form and the supporting documentation will remain confidential.**

A. PARTICULARS OF APPLICANT

1. Title (Mr./Miss) _____
2. Surname: _____
3. First Names: _____
4. Name by which applicant is known: _____
5. Current Age: _____
6. Date of birth: _____
7. Identity Number: _____
8. Place of birth: _____
9. Gender: _____
10. **Income:** Does applicant receive an income from any of the following sources:
    - SASSA Disability Grant _____
    - Return of Investments _____
    - Income of Trust _____
    - Property: Does the applicant own any fixed property or are there any fixed deposits in his/her name? If so, please provide details: _____

*Home address / Stand Number /Home address of other person (if applicable)

B. PARTICULARS OF FAMILY OR LEGAL GUARDIAN

Full names of parent/guardian: _____

Father: _____ Age: _____
Mother: _____ Age: _____

Occupation:
Father: _____ Income: _____
Mother: _____ Income: _____

Contact details
Phone 1: _____
Phone 2: _____
Email 1: _____

Email 2: _____

*Home address / Stand Number (Permanent Residential Address)

PARTICULARS OF OTHER RELAVTIVES IF YOU CANNOT BE REACHED:

1. Name: _____ Relation to applicant: _____

   Telephone Number: _____

2. Name: _____ Relation to applicant: _____

   Telephone Number: _____

According to your opinion: Cause of mental disability: _____

PARTICULARS OF SCHOOLING, REMEDIAL SCHOOL, TRAINING CENTRES OR INSTITUTIONS:

1. Name of School / Training Centre / Institution: _____
2. Highest grade of education: _____

PLEASE INDICATE THE DISABILITY OR IMPAIRMENT OF THE APPLICANT BELOW AND PROVIDE DETAILS:

DISABILITY / IMPAIRMENT	INDICATE	DETAILS OF DISABILITY / IMPAIRMENT
Intellectual Disability:		
Can follow instructions		
Response to discipline (Good/Average/Poor)		
Which method of discipline achieves the best results?		
Communication Impairment:		
Read (Only words or Sentences)		
Speaking (Only words/ Phrases/ Sentences)		
Hearing or Visual Impairment:		
Deaf/Hard of hearing		
Blind / Partially sighted		
Physical Disabilities:		
Needs assistance using the toilet during the day or night?		
Needs assistance bathing?		
Needs assistance to shave?		
Needs assistance with getting dressed?		
Needs assistance to tying shoes?		
Needs assistance with eating?		
Needs assistance to cut meat?		
Behavioural and Emotional:		
Moody		
Aggressive		
Destructive		
Tense		
Passive		
Affectionate		
Tearful		
Any other disabilities or impairments		
Social Skills		
Prefers to be alone		
Enjoys company		
Prefers the company of adults or children		
Shows a lot of interest in the opposite sex		
Mention any social problems, if applicable		

I, the undersigned parent/ guardian of _____

(Name of applicant)

Hereby gives consent to the Director for the following:

- Emergency operation: The signing of consent for the operation, as well as for the anaesthetic and making of necessary arrangements.
- To take photos of the above-mentioned applicant and to publish or use it, as seemed fit.
- To take the above-mentioned applicant on approved excursions.
- Although I believe that the Director will take necessary precautions, I undertake not to lodge any claims against the Director or Centre for any loss of property of the above-mentioned applicant.

_____

(Full name of Parent / Guardian)

Witness: **1.Name:**_____**Signature:**_____

2.Name:_____**Signature:**_____

Date: _____

UNDERTAKING FOR ADDITIONAL PAYMENT

I declare that I am aware that the disability grand that is payable to _____

(Name of applicant)

will in future be utilised by Wenakker Centre for the care of above-mentioned.

I undertake to make an additional payment with regard to the care of above-mentioned.

******In addition, there is a monthly co-payment payable over and above the grant. This amount will be increased annually, this will be discussed during the screening process.******

_____

(Full Name of Parent / Guardian)

Witness: **1.Name:**_____**Signature:**_____

2.Name:_____**Signature:**_____

Date: _____

PLEASE BRING ALL MEDICAL PSYCHOLOGICAL SCHOOL AND WELFARE REPORTS TO THE INTERVIEW.
PLEASE BRING I.D. DOCUMENT AND PROOF OF CURCH MEMBERSHIP ALONG.

C. MEDICAL CERTIFICATE FOR THE APPILCATION FOR ADMISSION TO WENAKKER CENTER

The required information is to be supplied by the applicant's Doctor.
FULL NAME OF APPLICANT
(Mr/Me):.....

Date of
Birth:.....
.....

Please indicate the following information with an **"X"**:

	EXCELLENT	GOOD	POOR	VERY POOR
1. General Condition of Health				
2. General Mental Condition				
3. General Memory				
4. Mobility				
5. General Condition of Hearing				
6. General Condition of Hands				
7. General Condition of Feet				
8. General Condition of Eyes				
9. General Condition of Lungs				
10. General Condition of Kidneys				
11. General Condition of Skin				

12. Mention any allergic conditions
    .....

13. Blood pressure and Vital signs at the examination
    .....

14. Mention any specific disease or illness that you are aware of, that you deem necessary to be taken into consideration with regards to admission:
    .....
    .....

15. Is the applicant on medication? Name Medication and dosage:
    .....
    .....15.1 Who prescribed the medication.....
    15.2 For what period has this medication been used?.....

16. Childhood diseases: Chickenpox.....
    Measles.....Mumps.....Other.....

17. Has the applicant been immunized against: Polio..... Smallpox..... DWT
    .....

18. Did the applicant undergo any operations
    .....
    .....
    .....

19. Any noticeable injuries or scars
    .....

20. Orientation and comprehension regarding:
    TIME:.....
    PLACE:.....
    PERSONAL SPHERE:.....

21. Does the applicant suffer from
    epilepsy.....

22. Do you suspect any organ
    abnormalities.....

23. Any particulars regarding the medical history of the applicant that needs to be taken into
    consideration.....
    .....
    .....
    .....
24. Does the applicant suffer from
    diabetes.....

25. Does the applicant have full control of his / her body functions
    .....

26. What, in your medical opinion, is the cause of the mental disability?
    .....

27. May you be approached for any additional information regarding the applicant's
    admission?

    .....
    .....

NAME OF DOCTOR:

……

……SIGNATURE:

……

……ADDRESS OF DOCTOR:

……POSTAL CODE:……

DATE: ……

PHYSICIAN

STAMP