THE box
LEARNING STUDIO

DO NOT FILL IN

Student Number	

APPLICATION DETAILS Version 1

Please E-mail Completed Application to study@theboxlearningstudio.co.za
Please Include a Copy of Your Latest Grade Results.
If You Have Completed Any Tertiary Courses Please Send That As Well.

- [ ] SA Citizen
- [ ] International

OFFICE USE ONLY

Learning Method: Glenvista Class Learning | Online Learning

School Details

SCHOOL		GRADE PASSED	

A: Student Personal Details

FULL NAMES																					
SURNAME													TITLE								
ID NUMBER														DATE OF BIRTH	Y	Y	Y	Y	M	M	D	D
RESIDENTIAL ADDRESS																					
POSTAL ADDRESS													CODE								
E-MAIL ADDRESS																					
CELLULAR NO											CONTACT NO (DAY)										

Important: The following section (B) is compulsory if the applicant is younger than 21 years of age.

B: Parent/Guardian Details

FATHER/GUARDIAN

FULL NAMES																					
SURNAME													TITLE								
ID NUMBER														DATE OF BIRTH	Y	Y	Y	Y	M	M	D	D
RESIDENTIAL ADDRESS																					
POSTAL ADDRESS													CODE								
E-MAIL ADDRESS																					
CELLULAR NO											CONTACT NO (DAY)										

MOTHER/GUARDIAN

SURNAME																					
FULL NAMES													TITLE								
ID NUMBER														DATE OF BIRTH	Y	Y	Y	Y	M	M	D	D
RESIDENTIAL ADDRESS																					
POSTAL ADDRESS													CODE								
E-MAIL ADDRESS																					
CELLULAR NO											CONTACT NO (DAY)										

Student Medical Information

Course Studying:

Branch:

Student Name & Surname: **Date of Birth:**

ID Number:

Drug Allergies (Please Check & List Type of Reaction):

Anaesthetics	**Erythromyc**
Anti Inflammatory	**Paracetamol**
Aspirin	**Penicillin**
Codeine	**Tetracycline**
Other	

Non-Drug Allergies (Please Include Reaction)

Current Medications (Please Specify if Chronic):

1.
2.
3.
4.
5.

Do You Have or Have You Ever Had a History of: (Please Check All That Apply)

Anemia	**Epilepsy**
Anxiety	**Heart Problems/Irregular or Rapid Heart Beat**
Asthma	**HIV/AIDS**
Bleeding Disorder	**Hypertension/Hypotension**
Breathing Disorder	**Migraine/Headaches**
Convulsions/Seizures	**Nervous Psychotic Disorders-Bipolar/Schizophrenia/OCD/ADHD**
Depression	**Tuberculosis**
Diabetes	
Other (Please Specify)	

Additional Information:

I/We have additional Hospital/Medical Cover ☐ **Yes** ☐ **No**

Name of Fund

Membership Number

Medical Scheme

Emergency Contact Information (In Order to be Contacted)

Name & Surname

Address

Relationship to Student

Cellular Nr (During the day)

Cellular Nr

Work Nr

Name & Surname

Address

Relationship to Student

Cellular Nr (During the day)

Cellular Nr

Work Nr

Name & Surname

Address

Relationship to Student

Cellular Nr (During the day)

Cellular Nr

Work Nr

I Declare the Information to be True and Correct as Stated.

Student Name & Surname

Parent/Guardian Name & Surname