

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

Programme:

Learning Method:

Class Learning

Online Learning

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																									
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																									
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																									
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