

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

☐

 Hybrid
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																	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) | <input type="text"/> |

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