



Machabeng College

International School of Lesotho,
 PO Box 1570, Maseru 100, Lesotho.
 Tel: (266) 22313224 Fax: (266) 22316109
 E-mail: machabhm@lesoff.co.za

STUDENT PERSONAL DETAILS

(Please fill in all of the white boxes)

A) STUDENT'S DETAILS

Family Name:	First Name:	Other Names:						
Date of Birth: dd.....mm.....yy.....	Age on Admission:	Gender:	Nationality:					
Date of Admission to Machabeng: dd.....mm.....yy.....	Class on First Admission to Machabeng (Please Tick): <input type="checkbox"/>	S1	S2	S3	S4	S5	IB1	IB2

B) FATHER'S DETAILS

Father's Title and Name:	Nationality:			
Father's Occupation:	Father's Employer:			
Please tick the appropriate boxes: <input type="checkbox"/>	Natural Parent	Step Parent	Guardian	Friend of Family

C) MOTHER'S DETAILS

Mother's Title and Name:	Nationality:			
Mother's Occupation:	Mother's Employer:			
Please tick the appropriate boxes: <input type="checkbox"/>	Natural Parent	Step Parent	Guardian	Friend of Family

D) BROTHERS AND SISTERS (Oldest First)

Name:	Current School:	Gender:	Current Age:
Name:	Current School:	Gender:	Current Age:
Name:	Current School:	Gender:	Current Age:
Name:	Current School:	Gender:	Current Age:

E) CONTACT DETAILS

Postal Address:	Physical Address:
Home Tel:	e-mail
Father - Work Tel:	Father - Cell:
Mother - Work Tel:	Mother - Cell:
Other Tel:	Fax:



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STUDENT MEDICAL RECORD

(Please fill in all of the white boxes)

This Form has two purposes:

1. to provide us with all the necessary information to adequately care for your child;
2. to enable us to have the permission we need to treat your child in case of accident or illness.

A) PHYSICIAN'S DETAILS

Name:	Tel:
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B) CONSENT TO TREATMENT

I hereby request my child to be given medical care as indicated below:

(Please tick your choice)

Emergency medical care	Yes	No
Temporary medication including paracetamol for illness	Yes	No
Prescribed medication in accordance with Physician's note	Yes	No
Date:	Signature (Parent/Guardian)	

C) HEALTH AND VACCINATION HISTORY

Disease or Condition	Year when sick	Year last tested/ vaccinated	Disease or Condition	Year when sick	Year last tested/ vaccinated
Chicken Pox			*Polio		
Whooping Cough			*Diabetes		
German Measles (Rubella)			*Epilepsy		
7-Day Measles (Rubeola)			*Heart Trouble		
Mumps			*Fainting		
Rheumatic Fever			*Asthma		
Tuberculosis			*Hearing Difficulties		
Frequent Ear Infection			*Vision Difficulties		
Tonsillitis			*Speech Difficulties		
Smallpox			*Allergies:		
Diphtheria			*Other:		
Typhoid			*Other:		
Tetanus			*Other:		

* Please give details below of any condition indicated by an asterix (*) above:

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If your child is currently under medical care or is routinely taking medication, please give details:

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D) CONTACTS IN CASE OF EMERGENCY

Work

Home

Cell

Name:	Tel:
Name:	Tel:
Name:	Tel:
Date:	Signature (Parent/Guardian)