



'n Program van



**ELJADA INSTITUTE FOR
OPTIMAL HUMAN
FUNCTIONING
P.O. BOX 21
OUDTSHOORN
6620**

APPLICATION FOR RESIDENCY

(NB A recent full length photo of the applicant must accompany the application)

1. **SURNAME:** _____

2. **FULL NAME:** _____

3. **NAME:** _____

4. **BIRTHDATE:** _____

5. **PLACE OF BIRTH:** _____

6. **HOME LANGUAGE:** _____ **RELIGION** _____

7. **IDENTITY NUMBER:** _____

8. **ADDRESS OF PARENT/GUARDIAN** _____

9. **TEL (CODE** _____ **)** _____ **(CELL)** _____

10. **SCHOOLS, CENTRES OR INSTITUTIONS THAT THE APPLICANT
ATTENDED - YEARS:**

Last date of attendance _____ **Grade passed** _____

TEL NO (044) 279 1740 FAKS (044) 279 1878
E-Pos: wlemmer@etime.co.za

11. Are you a member of a Medical Aid Yes/No

12. Name of Medical Aid:

Principle Member: _____ Membership nr. _____

13. Composition of family:

FATHER

Name	
Birthdate	
Occupation	
Income	

MOTHER

Name	
Birthdate	
Occupation	
Income	
Maiden name	

a) Are the parents related? Yes/No

b) If so, to what degree ? _____

14 **CHILDREN/SIBLINGS** (including –independant/married)

Name	Gender	Age

15. **Other residence**(eg Grandparents/borders)

16. FAMILY RELATIONSHIPS WITH REGARD TO THE APPLICANT:
(Comprehension, Insight, Acceptability)- Explain in short sentence.

Father: _____

Mother: _____

Brothers: _____

Sisters: _____

17. Why do you only apply now for occupancy.

18. What form of discipline is the applicant used too.

19. GENERAL INFORMATION WITH REGARD TO THE APPLICANT-
Supply details please:

a. Injections/occulations _____

b. Operations: _____

c. Children diseases: _____

d. Other serious illnesses: _____

e. Allergies: _____

f. Attacks or medical problem _____

g. Medication used regularly: _____

20. Pre-natal history: _____

a. Term of pregnancy: _____

b. Any abnormal circumstances during pregnancy: _____

21. Birth: _____

22. DEVELOPMENT HISTORY:

a. Sit _____ b. Crawl _____

b. Walk _____ d. What age did he/she attend
School _____

23. EMOTIONAL STATE/PERSONALITY

Excited: _____ Passive: _____

Short tempered: _____ Loveable: _____

24. ATTITUDE: Explain in short sentences

a. Can the person execute orders? _____

b. Is the person disciplined? _____

c. How well is the applicant's communication skills
developed.?

d. Is he/she influenced easily? _____

e. Does he/she make friends easily? _____

f. Describe his/her relationship towards the opposite gender:

25. How selfsufficient is the applicant with regard to :

a. Toilet control during the day: _____ Nighttime: _____

b. Eat with spoon: _____ Knife & Fork _____

c. Dress and undress: _____

d. Bath: _____ Washing hair: _____

e. Brushing teeth: _____ Making the bed: _____

f. Write: _____ Read: _____

26. Hobbies of the applicant: _____

27. Skills of the applicant: _____

28. Unusual Habits: _____

29. GENERAL

I, the undersigned, hereby declare that the above mentioned details provided by me, are correct.

SIGNATURE: _____

FATHER: _____

WITNESS: _____

MOTHER: _____

WITNESS: _____

GUARDIAN (if applicable):

Date of application:

NB FAMILIES ARE RESPONSIBLE FOR THE OCCUPANT WHICH ARE IN ELJADA. This responsibility, includes regular contact, visits, telephone calls, the payment of a family-contribution and taking the disabled on an outing. When property is damaged during an outburst the family are responsible for the damages.

POST TO : The Manager, Eljada Institute, P.O.Box 21, OUDTSHOORN,6620

MEDICAL REPORT

(For completion through the General Practitioner)

1. NAME OF APPLICANT: _____

2. ADDRESS: _____

3. FACTORS with regard to disability: _____

4. EPILEPSY (If applicable) _____

Types of attacks _____

Appearance per month _____

Current medication (Details please) _____

5. ALLERGIES: _____

6. PHYSICAL STATE:

Weight: _____ kg Length: _____ m

Bloodgroup: _____ Urine test: _____

Mention if problems exist with regard to:

Sight _____

Hearing: _____

Skin: _____

Heart: _____

Toraks: _____

Speech: _____

Any other fisical disability: _____

Birth control : _____

2. **MENTAL STATE:**

Nervous problems: _____

Psychotic states: _____

Prescribed medication: _____

3. **HISTORY OF ILLNESSES/DISABILITYIES IN FAMILIES: _____**

4. **GENERAL: _____**

SIGNATURE: _____

DATE: _____

Name, Address and telephone number of General Practitioner:
