

STUDENT ENROLMENT INFORMATION		CASES21 STUDENT ID							
Enrolment Date: ___/___/___		Birth Certificate Sighted:		YES <input type="checkbox"/>		NO <input type="checkbox"/>			
VSN _____		Immunisation Certificate Sighted:		YES <input type="checkbox"/>		NO <input type="checkbox"/>			
STUDENT DETAILS									
SURNAME:									
FIRST NAME:									
SECOND NAME:									
PREFERRED NAME:									
GENDER: <input type="checkbox"/> MALE		<input type="checkbox"/> FEMALE		BIRTH DATE: (DD/MM/YYYY) / /					
ADULT A DETAILS					ADULT B DETAILS				
GENDER: <input type="checkbox"/> F <input type="checkbox"/> M TITLE: MR/MS/MRS/MISS					GENDER: <input type="checkbox"/> F <input type="checkbox"/> M TITLE: MR/MS/MRS/MISS				
SURNAME					SURNAME				
FIRST NAME					FIRST NAME				
OCCUPATION					OCCUPATION				
EMPLOYER					EMPLOYER				
COUNTRY OF BIRTH					COUNTRY OF BIRTH				
LANGUAGE OTHER THAN ENGLISH: YES NO					LANGUAGE OTHER THAN ENGLISH: YES NO				
OTHER LANGUAGE:					OTHER LANGUAGE:				
INTERPRETER REQUIRED					INTERPRETER REQUIRED				
◆What is the highest year of school completed?					◆What is the highest year of school completed?				
		Year 12 or equivalent					Year 12 or equivalent		
		Year 11 or equivalent					Year 11 or equivalent		
		Year 10 or equivalent					Year 10 or equivalent		
		Year 9 or equivalent or below					Year 9 or equivalent or below		
◆What is the highest qualification level completed?					◆What is the highest qualification level completed?				
		Bachelor Degree or above					Bachelor Degree or above		
		Advanced Diploma/Diploma					Advanced Diploma/Diploma		
		Certificate I to IV (Including trade certificate)					Certificate I to IV (Including trade certificate)		
		No non-school qualification					No non-school qualification		
◆Parent A – currently employed Yes/No					◆Parent B – currently employed Yes/No				
If Yes		Current occupation			If Yes		Current occupation		
RELATIONSHIP OF ADULT A TO STUDENT					RELATIONSHIP OF ADULT B TO STUDENT				
		Parent					Parent		
		Step-Parent					Step-Parent		
		Foster Parent					Foster Parent		
		Relative					Relative		
		Friend					Friend		

THE STUDENT LIVES WITH ADULT A:				THE STUDENT LIVES WITH ADULT B:			
	Always				Always		
	Mostly				Mostly		
	Balanced				Balanced		
	Occasionally				Occasionally		
	Never				Never		
ADULT A HOME ADDRESS				ADULT B HOME ADDRESS (Tick if same as Adult A) <input type="checkbox"/>			
No & Street:				No & Street:			
Suburb				Suburb			
State		Postcode		State		Postcode	
ADULT A POSTAL ADDRESS				ADULT B POSTAL ADDRESS (Tick if same as Adult A) <input type="checkbox"/>			
Street/Box No:				Street/Box No:			
Suburb				Suburb			
State		Postcode		State		Postcode	
Send Correspondence addressed to:				Send Correspondence addressed to:			
		Adult A		Adult B		Both Adults	
ADULT A CONTACT INFORMATION				ADULT B CONTACT INFORMATION			
HOME PHONE No:				HOME PHONE No:			
MOBILE PHONE No:				MOBILE PHONE No:			
BUSINESS HOURS PHONE No:				BUSINESS HOURS PHONE No:			
Can we contact at work?		YES	NO	Can we contact at work?		YES	NO
EMAIL:				EMAIL:			
Do you wish to receive newsletters and family statements via email?				Do you wish to receive newsletters and family statements via email?			
		YES	NO			YES	NO
STUDENT ALTERNATIVE LIVING ARRANGEMENTS:							
Arranged by State/Out Of Home Care*							
<small>* State/Out of home care – students who have been subject to protective intervention by the Department of Human Services and live in alternative care arrangements, away from their parents. These DHS-facilitated living arrangements include living with relatives or friends, living with non-relative families (foster families) and residential care.</small>							
EMERGENCY CONTACT INFORMATION (OTHER THAN PARENTS)							
Name		Relationship to Student			Phone Number/s		
1							
2							
3							
4							
FAMILY DOCTOR DETAILS							
Doctor's Name:						PH:	
Does the primary family have a current Ambulance Subscription?						Yes	No
Medicare No:							
DEMOGRAPHIC DETAILS OF STUDENT							
♦In which country was the student born? Australia Other – Please Specify:							
What is the residential status of the student? Permanent Temporary							
Basis of Australian Residency: Eligible for Passport Holds Passport Permanent Residency Visa							

Date of Arrival in Australia: (dd/mm/yyyy) / /		Visa Expiry Date: / /		Visa Subclass:	
Does the student speak English?		YES	NO	◆ Does the student speak a language other than English at home? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, please specify:	
◆ <i>Is the student of Aboriginal or Torres Strait Islander origin? (Please circle)</i>					
No		Yes, Aboriginal		Yes, Torres Strait Islander	
Yes, Aboriginal & Torres Strait Islander					
◆ Questions marked with this symbol are asked as a requirement of the Commonwealth Government. All schools across Australia are required to collect the same information.					
Usual mode of transport to school:		Walking		Bicycle	
				School Bus	
				Driven	
Distance to school in kilometres:					
WHERE OFFERED DO YOU WISH YOUR CHILD TO PARTICIPATE IN RELIGIOUS EDUCATION CLASSES?				YES	NO
PRE-SCHOOL/ PREVIOUS SCHOOL DETAILS					
Name of Pre-School/Previous School:					
Date first enrolled in an Australian school:					
Language of previous education?					
STUDENT RESTRICTIONS DETAILS					
ACCESS RESTRICTIONS: IS THE STUDENT AT RISK?		YES	NO		
Is there an Access Alert for the student?		YES/NO (If Yes, then complete the following questions)			
Access Type:		Court Order	Family Law Order	Restraining Order	Other
*** Please provide a copy of any orders to the School. ***					
Is there an Activity Alert for the student?		NO	YES - If Yes, please describe the activity restriction:		
MEDICAL CONDITIONS DETAILS					
Does the student suffer impairments in any of the following areas:					
Hearing		Vision			
Speech		Mobility			
DOES THE STUDENT SUFFER FROM ASTHMA?		YES	NO		
ASTHMA MEDICAL CONDITION DETAILS (Answer the following ONLY if the student suffers from Asthma)					
Please indicate if your child suffers from any of the following symptoms: (Please circle all applicable)					
Coughing		Wheezing		Difficulty Breathing	
				Exhibits symptoms after exertion	
				Tight Chest	
Does the student take medication for asthma?		YES	NO		
If Yes please provide an Asthma Management Plan to the School					
ALLERGIES e.g. Anaphyllaxis					
Does the student have any allergies?		YES	NO		
If Yes, please specify: e.g. Nuts, shellfish, penicillin					
Does the student require an Epipen?		YES	NO		
If Yes please provide the school with a current Anaphyllaxis Action Plan from your doctor. Please provide Epipen.					

Name and dosage of other medication taken for allergies: e.g Claratyne

Is the medication taken as a preventative or in response to symptoms?	Preventative	Response
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OTHER MEDICAL CONDITIONS

Does the student have any other medical conditions?	YES	NO
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If Yes, please specify:

Symptoms:

Does the student take medication for the above medical condition?

Name and dosage of medication taken:

PERMISSIONS – See Parent Information Handbook for more information regarding the following permissions

HEAD LICE INSPECTION CONSENT:
I **DO/DO NOT** (please circle one) consent to the child named on this enrolment form to participate in the school’s head lice inspection program during his/her time at this school unless otherwise notified.

Signature of Parent/Guardian: _____ Date: ___/___/___

MEDIA /ULTRANET PUBLICATIONS:
I **DO/DO NOT** (please circle one) give permission for photographs and other visual information regarding my child to be used by the school for promotion and other educational purposes: eg school newsletter, school website, newspaper, television and Internet.

Signature of Parent/Guardian: _____ Date: ___/___/___

MEDICAL CONSENT :
In the event of illness or injury to my child whilst at school, on an excursion, or travelling to or from school:
I authorise the Principal or teacher-in-charge of my child, where the Principal or teacher-in-charge is unable to contact me, or it is otherwise impracticable to contact me to: **(cross out any unacceptable statement)**

Consent to my child receiving such medical or surgical attention as may be deemed necessary by a medical practitioner, Administer such first aid as the Principal or staff member may judge to be reasonably necessary.

Signature of Parent/Guardian: _____ Date: ___/___/___

Comments: _____

I certify that the information contained within this form is true and correct.

Signature of Parent/Guardian: _____ Date: ___/___/___

Please include a copy of Student Birth Certificate & Immunisation record with this form.