YARRAWONGA COLLEGE P-12
SCHOOL READINESS PROGRAM
ENROLMENT FORM

STUDENT ENROLMENT INFORMATION
SCHOOL READINESS PROGRAM FOR 2023 PREPS

STUDENT DETAILS

PERSONAL DETAILS OF STUDENT

Surname:			
First Given Name:			
Second Given Name:			
Preferred Name (if applicable):			
❖**Sex** (tick):	☐ Male ☐ Female	**Birth Date:** (dd-mm-yyyy)	_____ / _____ / _____

PRIMARY FAMILY HOME ADDRESS:

Parent/guardian's Name:			
No. & Street: or Box details			
Suburb:			
State:		**Postcode:**	
Telephone Number		**Silent Number:** (tick)	☐ Yes ☐ No
Mobile Number:		**Fax Number:**	

PRIMARY FAMILY EMERGENCY CONTACTS:

	Name	***Relationship*** (Neighbour, Relative, Friend or Other)	***Telephone Contact***	***Language Spoken*** (If English Write "E")
1				
2				
3				
4				

OTHER PRIMARY FAMILY DETAILS

Relationship of Adult A to Student: (tick one)	☐ Parent	☐ Step-Parent	☐ Adoptive Parent
	☐ Foster Parent	☐ Host Family	☐ Relative
	☐ Friend	☐ Self	☐ Other

The student lives with the Primary Family: (tick one)				
☐ Always	☐ Mostly	☐ Balanced	☐ Occasionally	☐ Never

PRIMARY FAMILY DOCTOR DETAILS:

Doctor's Name		**Individual or Group Practice:** (tick)	☐ Individual ☐ Group
No. & Street or Box No.:			
Suburb:			
State:		**Postcode:**	
Telephone Number		**Fax Number**	
Current Ambulance Subscription: (tick)	☐ Yes ☐ No	**Medicare Number:**	

STUDENT RESTRICTIONS DETAILS

ACCESS RESTRICTIONS

Is the student at risk?		☐ Yes	☐ No	
Is there an Access Alert for the student? (tick)		☐ Yes (If Yes, then complete the following questions)	☐ No (If No, move to the immunisation / medical condition details questions.)	
Access Type: (tick)	☐ Court Order	☐ Family Law Order	☐ Restraining Order	☐ Other
Describe any Access Restriction:				
Is there an Activity Alert for the student? (tick)		☐ Yes	☐ No	
If Yes, then describe the Activity Restriction:				

STUDENT MEDICAL DETAILS

MEDICAL CONDITION DETAILS:

Does the student suffer from any of the following impairments? (tick)	*Hearing:*	☐ Yes	☐ No	*Vision*	☐ Yes	☐ No
	Speech:	☐ Yes	☐ No	*Mobility:*	☐ Yes	☐ No
Does the student suffer from Asthma? (tick) If No, please go to the Other Medical Conditions section					☐ Yes	☐ No

ASTHMA MEDICAL CONDITION DETAILS:

Answer the following questions **ONLY** if the student suffers from any asthma medical conditions.

Please indicate if the student suffers from any of the following symptoms: (tick)	**If my child displays any of these symptoms please:** (tick)		
☐ Cough	Inform Doctor	☐ Yes	☐ No
☐ Difficulty Breathing	Inform Emergency Contact	☐ Yes	☐ No
☐ Wheeze	Administer Medication	☐ Yes	☐ No
☐ Exhibits symptoms after exertion	Other Medical Action	☐ Yes	☐ No
☐ Tight Chest	If yes, please specify:		

Has an Asthma Management Plan been provided to School?			☐ Yes	☐ No
Does the student take medication? (tick)	☐ Yes	☐ No	**Name of medication taken:**	
Is the medication taken regularly by the student (preventive) or only in response to symptoms? (tick)			☐ Preventative	☐ Response
Indicate the usual dosage of medication taken:			**Indicate how frequently the medication is taken:**	
Medication is usually administered by: (tick)	☐ Student	☐ Nurse	☐ Teacher	☐ Other
Medication is stored: (tick)	☐ with Student	☐ with Nurse	☐ Fridge in Staff Room	☐ Elsewhere
Dosage time	**Reminder required?** (tick)	☐ Yes ☐ No	**Poison Rating**	

OTHER MEDICAL CONDITIONS

(More copies of the other medical condition forms are available on request from the school.)

Does the student have any other medical condition? (tick)			☐ Yes	☐ No	
If yes, please specify:					
Symptoms:					
If my child displays any of the symptoms above please: (tick)					
Inform Doctor	☐ Yes	☐ No	Inform Emergency Contact	☐ Yes	☐ No
Administer Medication	☐ Yes	☐ No	Other Medical Action	☐ Yes	☐ No
			If yes, please specify:		
Does the student take medication? (tick)	☐ Yes	☐ No	**Name of medication taken:**		
Is the medication taken regularly by the student (preventive) or only in response to symptoms? (tick)			☐ Preventative	☐ Response	
Indicate the usual dosage of medication taken:			**Indicate how frequently the medication is taken:**		
Medication is usually administered by: (tick)	☐ Student	☐ Nurse	☐ Teacher	☐ Other	
Medication is stored: (tick)	☐ with Student	☐with Nurse	☐ Fridge in Staff Room	☐ Elsewhere	
Dosage time	**Reminder required?** (tick)	☐ Yes ☐ No	**Poison Rating**		

IS THERE ANY FURTHER INFORMATION WE SHOULD KNOW ABOUT YOUR CHILD?

Thank you for taking the time to complete this Student Enrolment form. We understand that the information you have provided is confidential and will be treated as such, but the details are required to enable staff to properly enrol your child at our school.

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

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

CONSENT TO MEDICAL ATTENTION AUTHORITY

In the event of illness or injury to my child whilst at 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:

- 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.
- Consent to my child receiving medical assessment or inspection by an authorized medical practitioner or registered nurse in relation to infectious diseases as detailed in Schedule 6 (Health Diseases) 2001

Signature of Parent/Guardian _____ Date _____
(Primary Family)

Signature of Parent/Guardian _____ Date _____
(Primary Family)

Contact Telephone No: Home _____ Mobile _____

Thank you for taking the time to complete this Student Information Form. The details are confidential but are required to enable staff to properly enrol your child at our school.