

<p>OFFICE USE ONLY Date received: _____ Application: _____ accepted / not accepted Birth Certificates, visas and immunisation details will be requested at time of formal enrolment.</p>
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**APPLICATION FOR ENROLMENT (CONFIDENTIAL)**

<b>1. PERSONAL DETAILS (PLEASE PRINT ALL DETAILS BELOW)</b>			
Child's surname	Given names	Date of birth	Sex (M/F)
Surname of parent/guardian	Given names	Mr/Mrs/Ms	
Residential Address (must be completed)		Postcode	
Nearest intersecting street			
Postal Address (if different from residential address)		Postcode	
Email Address			
Telephone – Home	Work (if convenient)	Mobile Phone No	
Are there any Family Court Orders regarding the day to day or long term care, welfare and development of the child? Please indicate (√) YES <input type="checkbox"/> NO <input type="checkbox"/>			
If applicable, year level child currently enrolled in (e.g. Year 7)			
If applicable, name of school at which the child is currently or was last enrolled:			
Are you applying to enrol in a specialist program at this school? Please indicate (√) YES <input type="checkbox"/> NO <input type="checkbox"/> Name of specialist program:			
Are there any siblings currently attending this school? Please indicate (√) YES <input type="checkbox"/> NO <input type="checkbox"/> Names and year levels:			
** Is your child currently under suspension from a school? Please indicate (√) YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/> If yes, name of school:			
** Has your child ever been excluded from a school? Please indicate (√) YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/> If yes, name of school:			
<b>2. PERMANENT RESIDENT OF AUSTRALIA?</b> Please indicate (√) YES <input type="checkbox"/> NO <input type="checkbox"/>			
If no, please indicate date entered Australia: _____ VISA SUB CLASS No: _____			
<b>3. Has your child been assessed by:</b> Speech Therapist <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Child Psychiatrist <input type="checkbox"/> Paediatrician <input type="checkbox"/> When was their last appointment : _____ When was the last assessment : _____			
<b>4. DISABILITY/MEDICAL CONDITION?</b> This information will assist the school principal with considering whether any specific or additional resources are required and available to assist the school with providing the best educational program for your child. Please indicate (√)			
Physical YES <input type="checkbox"/> NO <input type="checkbox"/>	Intellectual YES <input type="checkbox"/> NO <input type="checkbox"/>	Other YES <input type="checkbox"/> NO <input type="checkbox"/>	Medical Condition YES <input type="checkbox"/> NO <input type="checkbox"/>
Please outline nature of disability/medical condition:			
<b>I declare that the information provided on this form is true.</b> <i>If applying for a kindergarten or pre-primary program, I also declare that this is the ONLY application I have made.</i>			
Signature of parent/guardian _____		Date _____	
Signature of parent/guardian _____		Date _____	
Signature of parent/guardian _____		Date _____	