



NB. Colour Areas
for Office Administration ONLY

KEDGLEY INTERMEDIATE

2017 Enrolment Form

START DATE ENROLMENT NUMBER YEAR ROOM

TICK ✓✓	Yes	No
IN ZONE		

NEW ZEALAND BORN STUDENT			NOT NEW ZEALAND BORN		
<input type="checkbox"/> New Zealand Birth Certificate	<input type="checkbox"/> New Zealand Passport	<input type="checkbox"/> Proof of Address (most recent Power Bill)	<input type="checkbox"/> Custody Papers	<input type="checkbox"/> Foreign Birth Certificate	<input type="checkbox"/> Foreign Passport
				<input type="checkbox"/> Permanent Residence Permit/Visa	<input type="checkbox"/> Proof of Address
				<input type="checkbox"/> Student Visa/Expiry	<input type="checkbox"/> Parents Passport with Work Visa

STUDENT DETAILS

LAST NAME FIRST NAMES PREFERRED NAME TICK Male Female M F

ADDRESS POST CODE

HOME TELEPHONE NUMBER Confidential PARENTS MOBILE PHONE NUMBER DATE OF BIRTH

PARENTS E-MAIL ADDRESS: COUNTRY OF BIRTH:

PREVIOUS SCHOOL

Ethnicity 1. Main language spoken at home
 2. If Māori please state your Iwi Affiliation 1.
 3. 2.
 3.

Mother / Guardian Details (If not Mother please indicate relationship e.g. Step-Mother, Aunt, Guardian)
 Title First Name Surname
 Occupation Work Phone Mobile
 Address (If different from above—please include Postcode)

Father / Guardian Details (If not Father please indicate relationship e.g. Step-Father, Uncle, Guardian)
 Title First Name Surname
 Occupation Work Phone Mobile
 Address (If different from above—please include Postcode)

Other Emergency Contact Details (Please indicate relationship e.g. Friend, Neighbour, Guardian)
 Title First Name Surname

Other Emergency Contact Details (Please indicate relationship e.g. Friend, Neighbour, Guardian)
 Title First Name Surname

KEDGLEY INTERMEDIATE 2017 Enrolment Form

CUSTODY ARRANGEMENTS / ACCESS RESTRICTIONS (Please attach Documents)

What are your child's strengths and talents?

I give permission for images of my child to be published on the Kedgley Intermediate School Website and other media as part of publicity relating to school activities.

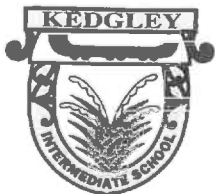
I will be notified when photos are going to be used by anyone other than Kedgley intermediate.

Parent's Signature:

In terms of the Privacy Act, I understand that the information on this form is collected to form part of the essential information the school holds on my child.

The records made from this information may be viewed on request at the school.

I approve the forwarding of information when my child transfers to another school. I further approve the forwarding of my child's name and address on request to a potential Intermediate or Secondary School.



Parent's Signature:



HEALTH DETAILS

KEDGLEY INTERMEDIATE 2017

STUDENT'S NAME: _____

FAMILY DOCTOR: _____

PHONE NO: _____

STUDENT DISABILITIES / or MEDICAL CONDITIONS

Please state any condition/s that the School Office and Sickbay should be aware of which might affect involvement in physical education or school life.

Please Tick (√) in box

Is your child taking any medication for the above condition?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

If yes, please state— _____

If your child has an asthma attack, do you give us permission to use Ventolin in the case of an emergency at school?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Do you give the school permission to give your child Panadol if needed?

EMERGENCY MEDICAL ASSISTANCE

In the case of an accident or sickness, and the school is unable to contact you, or if an ambulance is needed, do you give your permission for medical assistance to be sought or given to your child?

<input type="checkbox"/>	<input type="checkbox"/>
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EXTRA MEDICAL INFORMATION REQUIRED BY OUR SCHOOL DENTAL THERAPISTS

Does your child suffer or has your child suffer from any of the following?

	YES	NO
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to latex (Rubber)	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
HIV / Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>

I / We understand —

- 1 that the school has no Nurse or Registered Medical Practitioner to give medication
- 2 that the giving of the above mentioned medication will only be under the circumstances listed and according to the expressed written instructions given by the Parent/Guardian
- 3 that the school, in giving any medication, is acting responsibly and in the best express interests o my child but not responsible for any unforeseen circumstances
- 4 that any medication given will not be past the expiry date

NAME OF PARENT / GUARDIAN:

SIGNATURE: DATE:.....