



OFFICE USE ONLY	
Admission Date:/...../.....
Enrolment No:
Loaded on:	<input type="checkbox"/> Etap <input type="checkbox"/> Enrol
Year: Room:
House:

A copy of your child's birth certificate must accompany this Enrolment Form, this is a legal requirement. If your child has been immunized, we are required to sight proof. eg. Certificate, Plunket Book.

STUDENT'S PERSONAL DETAILS

LEGAL SURNAME:		LEGAL FIRST NAMES:	
GENDER: Male / Female		DATE OF BIRTH:	BIRTH CERTIFICATE: Y/N (Verified
HOME ADDRESS:			
CURRENT YEAR LEVEL :		PREVIOUS SCHOOL NAME:	
ETHNIC GROUP: (Please circle one) European NZer Maori NZer Other (Please specify)			
IWI AFFILIATION: (see attached schedule)			

Did your child attend one or more Early Childhood Education Services?	Please enter the numbers of hours per week attended	Name of E/C (hours per week)	Service 2 Name (hours per week)
Yes-for the last 6 months	Kindergarten		
Yes-for the last 2 years	Kōhanga Reo		
Yes-for the last 3 years	Playcentre		
Yes-for the last 4 years	Other (Please specify)		
Yes-for the last 5 or more			
Not regularly only occasionally with no on-going schedule.			

DETAILS OF PARENTS/CAREGIVERS:

SURNAME:	Mr/Mrs/Miss	FIRST NAME:
ADDRESS: (if not the same as above)		
PHONE: (Home)	(Mob)	PHONE (Work)
OCCUPATION:		WORK PLACE:
RELATIONSHIP TO STUDENT:	EMAIL:	
SURNAME:	Mr/Mrs/Miss	FIRST NAME:
ADDRESS: (if not the same as above)		
PHONE: (Home)	(Mob)	PHONE (Work)
OCCUPATION:		WORK PLACE:
RELATIONSHIP TO STUDENT:	EMAIL:	

EMERGENCY CONTACT:

(A person who can be contacted if immediate Caregivers can not be contacted)

SURNAME:	Mr/Mrs/Miss	FIRST NAME:
RELATIONSHIP TO STUDENT: (Mother, Father, Grandparent, Aunt Friend etc)		DAY TIME PHONE NUMBER:

Will your child be travelling to school on a bus? **YES / NO** If yes please circle which route

Arapohue	Baylys Beach	Hoanga	Kaihu	Waihue
Mahuta	Omamari	Tangowahine	Te Kopuru	

MEDICAL / HEALTH INFORMATION

Immunisation Certificate Sighted: Yes / No

Medical Problems: (degree: Mild / Moderate / Severe)
..... (degree: Mild / Moderate / Severe)

Please specify any other Medical Information which the school may need to know:

Prescription Medicine taken at school:
It is important that Prescription Medication for the student is held in the School Sick Bay. Please supply this medication clearly named with instructions if required.

I give permission for First Aid personnel at the school to administer prescription medicine:
I give permission for the school to act in an emergency should the need arise:
I give the school permission to dispense PARACETAMOL when / if necessary:
(Signed)

OTHER FAMILY MEMBERS LIKELY TO ATTEND THIS SCHOOL IN FUTURE:

Name:..... DOB:.....
Name:..... DOB:.....

PRIVACY ACT:

I give consent for this school to gain relevant information about this student from previous schools.
I give consent for this school to give relevant information to other schools, if requested.
I give consent for the school to give relevant information to Northland Health Services, Vision & Hearing Testers, Dental Services, Public Health Nurse, Truancy Officer.

Lunches in Schools - Please email provider directly if your child has a food allergy :
admin@cornerstonechildren.co.nz Please ensure that you put their name and school as DPS

Parent's Signature:.....