

2020 Enrolment Form

OFFICE USE ONLY

Re-Enrolment

Start Date _____ Student Number _____ Whanau _____ NSN Number _____

Student Information

YEAR 9	<input type="checkbox"/>	YEAR 10	<input type="checkbox"/>	YEAR 11	<input type="checkbox"/>	YEAR 12	<input type="checkbox"/>	YEAR 13	<input type="checkbox"/>
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Year Level Student is applying for:

First Name(s) _____ Surname _____

Date of Birth _____ Student Cellphone _____
(Copy of Birth Certificate or passport must be attached)

Home Address _____
_____ Postal Code _____

Ethnicity (tick one or more boxes)

*If your child was born in NZ a copy of a Birth Certificate or Passport must be attached.
If your child was not born in NZ a copy of Passport and a Visa must be attached.*

NZ Māori Hapu/Iwi _____
Ngati Whakaue Affiliated YES NO

Pacific Island Please State _____

NZ European

Asian Please State _____

Other European Please State _____

Other Please State _____

Transfer Details

Name of previous school _____ Town/Country _____

Have you previously been enrolled in a Kura Kaupapa Māori or Bilingual Unit? YES NO

Is your daughter currently in a digital class? YES NO

Any personal, home or social circumstances which will assist in understanding the student. *If applicable.* _____

Support Agency _____ Case Worker _____

Any sporting/cultural interests and/or achievements? _____

Student Lives with?

Both Parents	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Father	<input type="checkbox"/>	Other	<input type="checkbox"/>
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NB If there are any documents pertaining to Custody, Access, Protection Orders etc please provide copies for our records. We are unable to uphold verbal instructions without legal documentation on file.

Parent/Caregiver Information

Caregiver 1		Caregiver 2	
Title		Title	
Surname		Surname	
Firstname		Firstname	
Street Address		Street Address	
Suburb		Suburb	
City & Post Code		City & Post Code	
Home Phone		Home Phone	
Cellphone		Cellphone	
Email		Email	
Occupation		Occupation	
Workplace		Workplace	
Work Phone		Work Phone	
Relationship to student		Relationship to student	

Sibling Information

Number of Children in the family _____ Place in Whanau/Family _____

Do you have siblings attending or who have attended Rotorua Girls' High School? YES NO

Name _____ Year(s) of Enrolment _____

Name _____ Year (s) of Enrolment _____

Emergency Contact (Other than Above)

Name _____ Relationship to student _____

Contact Number _____ Contact Number _____

Declaration

I / We also agree to the following:

1. Requesting relevant information from other schools for enrolment purposes
2. Forwarding relevant information to another school for enrolment purposes
3. Forwarding relevant information to other institutions for the purpose of qualifications entry
4. Using information for statistical purposes
5. Using our daughter's name and photo on the school website and other school publications
6. I / we agree to our daughter / ward complying with all school rules and policies including uniform, attendance, extra-curricular/sports fees
7. To pay any fees or levies set, and for any careless damage of school property.
8. I agree that any information can be obtained and disclosed under the Privacy Act 1993.

Student Signed _____ Dated _____

Parent/Caregiver Signed _____ Dated _____

Parent/Caregiver Signed _____ Dated _____

Health Information

Medical Contact Details

Doctor _____ Dentist _____

Current Medical Information

Immunisation – Has the student received all available vaccinations/immunisations?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Medication – I consent to Panadol be administered if deemed necessary?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Mobile dental clinic – I consent to the student accessing the mobile dental clinic.

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Current Medical Conditions

Condition	Tick Yes or No				Details
	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Arthritis	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Asthma	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Diabetes	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Epilepsy	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Hearing Loss	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Impaired Vision	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Rheumatic Fever	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Other (please specify)	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	

Allergies

Condition	Tick Yes or No				Details
	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Food	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Medication	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Stings	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Other	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	

Does the student suffer from any other medical condition or disability that we as a school should be aware of?
