Lakelands PRIMARY SCHOOL

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Date received:		
Birth certificate sighted:	YES ☐	NO ☐
Immunisation records	YES ☐	NO ☐
Proof of Residence	YES ☐	NO ☐
Visa/Passport sighted	YES ☐	NO ☐
Family Court Order sighted	YES ☐	NO ☐
APPLICATION:	**ACCEPTED/NOT ACCEPTED**	

2019
APPLICATION FOR ENROLMENT FORM
LAKELANDS PRIMARY SCHOOL
YEARS 1-6

1. PERSONAL DETAILS (PLEASE PRINT ALL DETAILS BELOW)

Child's surname	Given names	Date of birth	Sex (M /F)

Surname of parent/responsible person	Given names	Mr/Mrs/Ms

Residential Address (must be completed)	Postcode

Nearest intersecting street

Postal Address (if different from residential address)	Postcode

Telephone – Home	Mobile Phone No

Work (if convenient)	Email

Are there any Family Court Orders regarding the day to day or long term care, welfare and development of the child?
Please indicate (√) YES ☐ NO ☐

If applicable, year level child currently enrolled in (e.g. Year 6)

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 ☐ NO ☐
Name of specialist program:

Will there be any brothers or sisters attending this school? Please indicate (√) YES ☐ NO ☐
Names and year levels:

** Is your child currently under suspension from a school? Please indicate (√) YES ☐ NO ☐ N/A ☐
If yes, name of school:

** Has your child ever been excluded from a school? Please indicate (√) YES ☐ NO ☐ N/A ☐
If yes, name of school:

2. WAS APPLICANT BORN IN AUSTRALIA Please indicate (√) YES ☐ NO ☐

PERMANENT RESIDENT OF AUSTRALIA? Please indicate (√) YES ☐ NO ☐

If no, please indicate date entered Australia:_____ VISA SUB CLASS No:_____

LANGUAGE SPOKEN AT HOME? _____

BACKGROUND LANGUAGE OTHER THAN ENGLISH? _____

3. DISABILITY/MEDICAL CONDITION?
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	Intellectual	Other	Medical Condition
YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

Please outline nature of disability/medical condition:

I declare that the information provided on this form is true. ***If applying for a kindergarten or pre-primary program, I also declare that this is the ONLY application I have made.***

Signature of parent/responsible person _____ Date _____

*** These questions are unlikely to apply to kindergarten and pre-primary children.*

FORM 1 – STUDENT HEALTH CARE SUMMARY

SECTION A

School:	Year: Form: Teacher:
Student's name:	Date of birth:
Address:	Gender: Male/Female

FAMILY CONTACT DETAIL	MEDICAL DETAILS
Name: Relationship to student: Address:	Medical practice: Doctor 1: Telephone: Doctor 2: Telephone:
Telephone: (W) (H) (M)	Do you have ambulance insurance? Yes ☐ No ☐ Insurance provider: **If there is a medical emergency, parents/carers are expected to meet the cost of an ambulance.**
Name: Relationship to student:	List any essential information that could affect your child in an emergency e.g. allergy to penicillin.
Telephone: (W) (H) (M)	Medicare No. (If required – for children requiring regular emergency care): Card number: Expiry date:

ADMINISTRATION OF MEDICATION

Written authorisation must be provided for staff to administer any form of medication at school.
Long term medication – Complete the *Medication* section of the relevant health care plan – see below.
Short term medication - Request an *Administration of Medication* form to complete and return to the principal or class teacher.
Note: *All medication required must be supplied by parents/carers*

INFORMED CONSENT

Your child's health care information will be shared with staff on a need to know basis unless otherwise stated.
Do you give permission for the school to share your child's health care information? **Yes ☐ No ☐**
Note: *If your child is enrolled in a TAFE, PEAC or an alternative education program, this includes the transfer of their health care information to the principal or manager of that program.*
If no, and the information is to be restricted, who can be informed of your child's health care information? _____

Does your child have one or more health condition(s) that will ***require support*** from school staff?
No ☐ - Sign below and return Section A of this form to the school office. If your child's requirements change, please notify the school.
Signature: _____ Date: _____
Yes ☐ - Complete the remainder of this form and return to the school office. You will be given additional forms to complete.
List your child's health condition(s): _____

SECTION B – IN THE FOLLOWING TABLE, PLEASE INDICATE YOUR CHILD'S CONDITION(S) WHICH REQUIRE THE SUPPORT OF SCHOOL STAFF

(In response to the information below, you will be given further forms for specific health conditions to complete)

Health conditions	Tick health condition	Will school staff require specific training to support your child?
Severe Allergy/Anaphylaxis	☐	YES ☐ NO ☐
Minor and Moderate Allergies	☐	YES ☐ NO ☐
Diabetes	☐	YES ☐ NO ☐
Seizures	☐	YES ☐ NO ☐
Asthma	☐	YES ☐ NO ☐
Activities of Daily Living	☐	YES ☐ NO ☐
Other Conditions or Needs (Please specify)		
	☐	YES ☐ NO ☐
	☐	YES ☐ NO ☐
Has your child's Medical Practitioner provided a health care plan to assist the school to manage the condition?		YES ☐ NO ☐ If yes, advise the Principal

If you have ticked Yes for specific staff training, please discuss the type of training needed with the principal.

Name: **Date of Birth:** **School:**

SECTION C: CONSENT FOR PHOTO IDENTIFICATION ON YOUR CHILD'S HEALTH CARE PLAN

If your child has a condition where an emergency may occur, please indicate whether you give consent for staff to place your child's medical details and photo on view to provide immediate identification.

I give permission for my child's medical details and photo to be on view for staff. Yes ☐ No ☐

If yes, please attach photo to the relevant health care plan(s).

SECTION D: MEDIC ALERT INFORMATION

Does your child have a Medic Alert bracelet or pendant? Yes ☐ No ☐
If yes, provide details:_____

Signature:

Parent/Carer Signature: _____ Date: _____

Parent/Care Name: _____

ON COMPLETION OF THIS FORM, PLEASE REQUEST AND COMPLETE THE RELEVANT HEALTH CARE PLANS

Note: Where appropriate students should be encouraged to participate in their health care planning.

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Does the child have an allergy that needs to be flagged on SIS? Yes ☐ No ☐ Date:

Have relevant health care plans been issued to the parent? Yes ☐ No ☐ Date:

Has the principal been informed if:

- specific training is required to support the student? Yes ☐ No ☐
- the student's health care information is to be restricted? Yes ☐ No ☐

Date *Student Health Care Summary* was completed and uploaded on SIS: / /