ENROLMENT AND INFORMATION FORM – IN ZONE / OUT OF ZONE
MOUNT ROSKILL INTERMEDIATE SCHOOL

Confidential – for school records only

FAMILY NAME: _____

FIRST NAME: _____

PREFERRED NAME: _____

Male/Female: Male/Female

Date of Birth: _____

Address: _____

_____

Primary Caregiver(s): _____

Family Email: _____

Home Telephone(s): _____

Ethnic Group(s): _____

Language(s) Spoken at Home: _____

☐ NZ Citizen OR ☐ NZ Resident

Born in NZ: Yes/No

Date of Entry Into NZ: _____

Custody Issues: Yes/No *please specify* _____

_____

2nd Address *(if applicable; for Father/Mother):* _____

_____

Time in New Zealand Schools: _____ Years _____ Months

Last School Attended: _____

Last Year Level: _____

Overseas School: _____

Level: _____

PARENT/CAREGIVER COUNTRY OF BIRTH

Birthplace of Father: _____

Birthplace of Mother: _____

Refugee Status: Q/R

Father's Name: _____

Workplace: _____

Workplace Telephone(s): _____

Mobile: _____

Email: _____

Mother's Name: _____

Workplace: _____

Workplace Telephone(s): _____

Mobile: _____

Email: _____

Primary Caregiver: *(if different from Father/Mother)*

_____

Telephone(s) _____

EMERGENCY CONTACT

Relationship: _____

_____

Name: _____

Telephone: _____

Doctor's Name: _____

Doctor's Phone No: _____

BROTHERS/SISTERS WHO HAVE ATTENDED IN THE PAST OR WILL ATTEND IN THE FUTURE:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

- PLEASE ATTACH EVIDENCE OF ADDRESS e.g. electricity or telephone account.
- Every enrolment MUST include – a copy of the child's New Zealand Birth Certificate / Birth Certificate and Passport if from overseas

☐ I give permission for photos of my child to be used in school promotional material e.g. newsletters, website, prospectus.

☐ I give permission for the above information to be forwarded to appropriate educational health institutions.

Signed: Parent/Caregiver: _____ Date: _____

OFFICE USE ONLY

Year: 7/8 ☐ ESOL ☐ Work Permit

Room Number: _____ ☐ Student Permit

HEALTH INFORMATION FORM
MOUNT ROSKILL INTERMEDIATE SCHOOL

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Student Name: _____ Date of Birth: _____

This form is comprehensive to assist our health professionals at Mount Roskill Intermediate School to help your child maintain good health and also to assist them in an emergency.

Does your child have a medical condition? Yes/No

What condition is this?

☐ Asthma

☐ Diabetes

☐ Heart

☐ Allergy: *please specify* _____

☐ Epilepsy

☐ Special Needs

☐ Sight/Hearing

☐ Learning Needs

☐ Other: *please specify* _____

Comment: _____

Is any treatment or medication required at school on a daily basis? Yes/No

Comment: _____

Is any treatment required in an emergency? Yes/No

What treatment is required? _____

Do you need to speak to someone about your child's condition and treatment? Yes/No

☐ I give permission for the school nurse to administer medications as required.

Medication: _____

Dosage: _____

Time: _____

Date: _____

Parent/Caregiver Signature: _____

I give permission for the school to act independently and seek medical aid if I am unable to be contacted in an emergency.

Date: _____

Parent/Caregivers Signature: _____