



KAIRANGA SCHOOL
For Life We are Learning

ENROLMENT FORM

FAMILY NAME: _____ **FIRST NAMES:** _____

ADDRESS: _____ **Preferred Name:** _____
 _____ **Telephone:** _____

Date of Birth: _____ **Gender:** Male / Female

Country of Birth: _____

Ethnic Origin: N.Z. European Pacific Island _____
 N.Z. Maori Other _____

Iwi: _____

Language Spoken at Home: English NZ Maori Other _____

Number of Siblings: _____ **Place in Family:** _____

Younger Siblings:

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

Previous School / Pre-school: _____ **Class Level:** _____

PARENTS / CAREGIVERS / GUARDIANS

Mother: **Name:** _____ **Prime Caregiver:** *(if not Mother or Father)*

Address: _____ **Name:** _____
 _____ **Address:** _____

Occupation: _____ **Occupation:** _____
Workplace: _____ **Workplace:** _____
Hours of Work: _____ **Hours of Work:** _____
Phone: (Home) _____ **Phone: (Home)** _____
(Work) _____ **(Work)** _____
Ethnic Origin: _____

Father: **Name:** _____

Address: _____

Occupation: _____

Workplace: _____

Hours of Work: _____

Phone: (Home) _____

(Work) _____

Ethnic Origin: _____

Legal Guardians – Relationship to Child

Single Parent Family: Yes / No

The information contained in this form is personal and as such is governed by the Privacy Act 1993. The information is necessary to maintain an accurate data base on our pupils. Some information is required by MOE for statistical purposes.

Emergency Contacts (in case parents / caregivers cannot be contacted in an emergency)

1. Name: _____ 2. Name: _____
Phone: _____ Phone: _____
Address: _____ Address: _____
Relationship to child: _____ Relationship to child: _____

Medical Information

Doctor: Name: _____ Phone: _____

Dentist: Name: _____ Phone: _____

Medical Conditions

Please indicate any conditions your child has

Asthma Headaches Nose Bleeds Epilepsy
Fainting Diabetes Allergy to Bee Stings Eczema

Allergies: _____

Other: _____

Will the school hold medication for any of the above conditions?

(For Bee Stings and Asthma the school requires clearly named medication for your child in case of an emergency)

I give permission for my child to be given panadol Yes / No

I give permission for sunscreen to be used on my child Yes / No

Birth Certificate Sighted Yes / No

(New Entrants only)

Immunisation (New Entrants only)

Immunisation Certificate Sighted Yes / No

Fully Immunised Yes / No

If not fully immunised tick boxes for diseases, which have been immunised against.

Hepatitis B Tetanus Measles
Polio Pertussis Mumps
Diphtheria Hib Rubella

Vision Wears glasses Yes / No

Hearing State nature of condition: _____

Speech State nature of condition: _____

General Information

Permission to participate in Bible-In-Schools programme Yes / No

I / We consent to our child being videoed / photographed at school Yes / No

I / We would like to receive the weekly school newsletter by email: Yes / No

If yes, please provide the following information:

First Name: _____ Last Name: _____

Email address: _____ (please print clearly)

Signature: _____

Date: _____