



BROOME PRIMARY SCHOOL

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2021 Student Re-enrolment Form

Student Details

Surname: _____ Residential Address: _____

Legal Surname: _____

1st Name: _____ Broome WA 6725

2nd Name: _____ Country of Birth: _____

Preferred Name: _____ Home Phone: _____

Date of Birth: ____/____/____ Mobile Phone: _____

Male Female Fax: _____

Date you wish the student to commence at BPS: _____

Year Level: _____ Form: _____ Faction: _____

Parent/Caregiver Details

Child lives with Mother Father Both Parents Neither Parent
 Access Restriction Yes No **If 'Yes' legal documentation needs to be attached**

In the box provided please indicate order of contact to be used (e.g.: 1st, 2nd, 3rd).

Mother/Caregiver Details **Father/Caregiver Details**
 If not Mother please indicate relationship e.g. Step mother, Aunt, Guardian _____
 If not Father please indicate relationship e.g. Step father, Uncle, Guardian _____

| | |
|------------------------------|------------------------------|
| Title: _____ (Mrs, Ms, Miss) | Title: _____ (Mr) |
| Surname: _____ | Surname: _____ |
| 1 st Name: _____ | 1 st Name: _____ |
| Occupation: _____ | Occupation: _____ |
| Employer: _____ | Employer: _____ |
| Work Phone: _____ | Work Phone: _____ |
| E-Mail: _____ | Email: _____ |
| Mobile: _____ | Mobile: _____ |
| Postal Address: PO Box _____ | Postal Address: PO Box _____ |
| _____ | _____ |

Please indicate Salutation for mailing purposes: _____
(I.e. Mr & Mrs, Ms, Miss, Mr OR Mr Smith & Miss Jones)

Emergency Contact Details

Person to contact other than Parent/Caregiver

Title: _____ (Mr, Mrs, Ms, Miss)

1st Name: _____

Surname: _____

Address: _____

Phone: _____

Emergency Contact Details

Person to contact other than Parent/Caregiver

Title: _____ (Mr, Mrs, Ms, Miss)

1st Name: _____

Surname: _____

Address: _____

Phone: _____

Please fill in reverse side of form

Student Details – Additional Information

Religion: _____ Religious Instruction Yes No

Students First Language _____ Main Language spoken at home _____

Is the student of Aboriginal or Torres Strait Islander origin? Yes No
**If YES please indicate* Aboriginal Torres Strait Islander

Do you give consent for your child's photo to be used in publications? Yes No
(eg: School website, Newsletter, Newspapers, Videos, etc)

Do you give consent for Release of Information regarding: Yes No
 Individual Awards?
 E.g. : Career Information (to Industry Groups)?

Health Benefit Card Yes No

Is this student in the care of the Child and Family Services (CPFS)? Yes No
If YES, please specify the name of the CPFS Case Manager, their CPFS District and their contact phone number:

Is this student subject to any court orders in respect of their care, welfare and development? Yes No
If YES, please specify and attach supporting document:

Has your child previously been in an Education Support Program Yes No

Country of Birth _____

Permanent Resident Yes No Visa Expiry Date: _____
 Date Entered Australia _____ Visa Sub-class No: _____

Previous School (if applicable) _____

Movement reason (if applicable) _____

Student Details – Medical / Health

Does the student have a disability? Yes No

If YES, please specify: _____

Does the student have a medical condition or intensive health care need? Yes No

If YES, please specify:

| | |
|---|---|
| <input type="checkbox"/> Allergy – Anaphylaxis | <input type="checkbox"/> Hearing condition (e.g. otitis media) |
| <input type="checkbox"/> Allergy – Other _____ | <input type="checkbox"/> Mental health or behavioural (e.g. depression, ADD/ADHD) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Diagnosed migraine/headaches | <input type="checkbox"/> Seizure Disorder (e.g. epilepsy) _____ |
| <input type="checkbox"/> Intensive Health Care Need (e.g. tube feeding) | <input type="checkbox"/> Other, please specify _____ |

If the student has a medical condition or intensive health care need, you will also need to complete a separate Health Care Authorisation

Medical Practice: BRAMS or Broome Hospital

Broome Doctors Broome Hospital Broome Medical Clinic

Drs Name: _____

Do you have ambulance cover? Yes No
(If there is a medical emergency parents or guardians are expected to meet the cost of the ambulance).

Do you give the school permission to:

Administer First Aid Yes No Call a Doctor Yes No Call a Dentist Yes No

Name of person enrolling student: _____

Signature: _____ Date: _____

Office Use Only

Birth Certificate Sighted Yes No
 Enrolment Date: ____/____/____

Immunisation records provided Yes No
 Date of Transfer Note Sent: ____/____/____

Entered on Integris by: _____