

BROOME PRIMARY SCHOOL

Weld Street, PO Box 1744, Broome WA, 6725. Ph: 08 9194 7500

Email: broome.ps@education.wa.edu.au

2023 Student Re-Enrolment Form

Student Details

Surname:	_____	Residential Address:	_____
Legal Surname:	_____		_____
1 st Name:	_____	Broome WA 6725	
2 nd Name:	_____	Country of Birth:	_____
Preferred Name:	_____	Home Phone:	_____
Date of Birth:	____/____/____	Mobile Phone:	_____
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Work Phone:	_____
Date you wish the student to commence at BPS: _____			
Year Level:	_____	Form:	_____
		Faction:	_____

Parent/Caregiver Details

Child lives with Access Restriction Mother Yes Father No Both Parents Neither Parent
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 <input type="checkbox"/>	Father/Caregiver Details <input type="checkbox"/>
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: _____

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)? Yes No

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) _____

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:

Name of person enrolling student: _____

Signature: _____ Date: _____ 2023

Office Use Only

Birth Certificate Sighted Yes No Immunisation records provided Yes No
 Enrolment Date: ____/____/____ Date of Transfer Note Sent: _____ Entered on Integris by: