PATHWAYS TO POPS

Enrolment Form – Term 4, 2019

Enrolments accepted from Monday 9th September

CHILD'S NAME…….. Date of Birth ____/____/_____

Mother's Name……

Address……

Phone: Home……..Work……..Mobile……

Father's Name……

Address……

Phone: Home……..Work……..Mobile……

Does your child have any medical problems, take medication, or have any special social, emotional needs or learning needs? Please give details below.

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Family Doctor's Name:……..Phone:……

Family Dentist's Name:……..Phone:……

Medicare Card No:……..Ambulance Subscription No:……

EMERGENCY CONTACTS ~ In case of emergency, or if your child is not to be collected by you, please list <u>2 PEOPLE</u> who can be contacted to collect your child.

NAME……Phone……Relationship……

NAME……Phone……Relationship……

CONSENT TO MEDICAL ATTENTION

In the event of any illness or injury to my child whilst in the Pathways to POPS Program I authorise the principal or teacher-in-charge of my child, where the principal or teacher-in-charge is unable to contact me, or it is impracticable to contact me (cross out any unacceptable statement)

- consent to my child receiving such medical or surgical attention as may be deemed necessary by a medical practitioner,
- administer such first aid as the principal or staff member may judge to be necessary.

SIGNATURE: ……..Parent/Guardian DATE:……

PHOTOGRAPH AND INTERNET AUTHORISATION

I _____ the parent/legal guardian of the above child provide permission for photographs to be taken for and on behalf of Park Orchards Primary School (Dept of Education & Training) involving the said child. I acknowledge that ownership of the photographs will remain with Park Orchards Primary School and I authorise their use or reproduction for any reasonable purpose, including the internet/intranet within the discretion of the Dept of Education & Training (DET). I understand and agree that if I wish to withdraw this authorisation, it will be my responsibility to inform Park Orchards Primary School in writing.

SIGNATURE: ……..Parent/Guardian DATE:……

PATHWAYS TO POPS ~ CREDIT CARD AUTHORISATION

NAME ON CREDIT CARD: _____ EXPIRY DATE: _____/_____

NO: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ **VISA / MASTERCARD**

DAY TIME PHONE NUMBER: _____ SIGNATURE: _____ $250.00