



193 Nayland Road
Stoke, Nelson 7011
Phone (03) 5477131

Email: broadgreen@broadgreen.school.nz

STUDENT DETAILS

Student's **Legal** Family Name : _____ Student's Full Names: _____
Family Name (as per birth certificate) First & Middle Names (eg Ross Stuart)

Students Preferred Family Name: _____ Student's Preferred Name: _____
Family Name First Name

Current School: _____ Year level (start at) 7 or 8 Gender: F / M Date of Birth: _____

Confirmation of Residency

The intermediate is required to confirm the residency of all students. Please confirm student eligibility (tick one box and **attach copy**)

- a NZ citizen (attach copy of NZ birth certificate or NZ passport or NZ citizenship certificate)
- a NZ or Australian resident (attach copy of other passport showing NZ residence class)
- an Australian citizen (attach copy of Australian passport)
- Is not a Citizen or Resident of NZ nor a citizen of Australia (provide valid student visa/permit with conditions containing "Domestic Student")

Country of Birth: _____ Country of Citizenship _____ First language (spoken at home): _____

An Ethnic Group is required by the Ministry of Education for statistical purposes

Please tick one or more boxes:

- NZ European/Pakeha Maori* Fijian Tongan Samoan Niuean Cook Island Maori Other European Other _____

* If the student is of a New Zealand Maori descent, please record up to 3 Iwi affiliations.

Iwi: 1 _____ 2 _____ 3 _____

Address child lives primarily at: _____
 Does a shared care arrangement exist for this child? Yes No With Whom? _____ (indicated below*)

PRIMARY CAREGIVERS (Main residence)

First and Family Name: Mr/Mrs/Ms/Miss/Dr	First and Family Name: Mr/Mrs/Ms/Miss/Dr
Relationship to student:	Relationship to student:
Address: <small>Proof of residence may be requested</small>	Address: <small>Proof of residence may be requested</small>
Home Phone:	Home Phone:
Work No: Workplace:	Work No: Workplace:
Cellphone:	Cellphone:
Email: (our preferred means of contact)	Email: (our preferred means of contact)

SECONDARY CAREGIVERS (Secondary Residence – if applicable)

Please tick which arrangement fits this caregiver:
 SHARED CARE – parent listed about is main caregiver, parent listed here has regular care * 50/50 shared care other regular arrangement
 Parent/Caregiver not living with student has legal access to their information

First and Family Name: Mr/Mrs/Ms/Miss/Dr	First and Family Name: Mr/Mrs/Ms/Miss/Dr
Relationship to student:	Relationship to student:
Address: <small>Proof of residence may be requested</small>	Address: <small>Proof of residence may be requested</small>
Home Phone:	Home Phone:
Work No: Workplace:	Work No: Workplace:
Cellphone:	Cellphone:
Email: (our preferred means of contact)	Email: (our preferred means of contact)

EMERGENCY CONTACT (a person who can be contacted other than the above eg friend, neighbour or grandparent.)

Full Name:	Relationship with Student:
Cellphone:	Daytime Phone numbers:

Legal Access: If a person does not have legal access to your child please provide a copy of the Court Order relating to the person named below:

Name: _____ Court Order attached (please tick)
 This request is made in the interests of the school providing good pastoral care for your child. Without the documentation the school has limited powers to act.

HEALTH INFORMATION

The ongoing health and wellbeing of your child is the reason we require the following information. Please answer all questions in full.

Does your child have any of the following conditions?	Severity of Condition:	Medication required
Arthritis	Mild/Moderate/Severe	
Asthma	Mild/Moderate/Severe	
Diabetes	Mild/Moderate/Severe	
Eczema	Mild/Moderate/Severe	
Hearing loss	Mild/Moderate/Severe	
Heart Condition	Mild/Moderate/Severe	
Impaired Vision	Mild/Moderate/Severe	
Other:		

Does he/she suffer an allergic reaction to:	Severity of Condition:	Medication required
Food:	Mild/Moderate/Severe	
Medication	Mild/Moderate/Severe	
Stings	Mild/Moderate/Severe	
Other:	Mild/Moderate/Severe	

Are there any other medical problems/issues we should be aware of?

VACCINATIONS (my child has had the following vaccinations)

<input type="checkbox"/> Yes <input type="checkbox"/> No 6 weeks	<input type="checkbox"/> Yes <input type="checkbox"/> No 15 months	Notes:
<input type="checkbox"/> Yes <input type="checkbox"/> No 3 months	<input type="checkbox"/> Yes <input type="checkbox"/> No 11 year	
<input type="checkbox"/> Yes <input type="checkbox"/> No 5 months	<input type="checkbox"/> Yes <input type="checkbox"/> No 12 year	

Medical Centre/Family Doctor:	Phone:
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Prescribed Medication: Please contact the school office if you would like us to hold medication for your child.

As a Health and Safety Requirement, if you have indicated that you child has any of the following conditions:

Anaphylaxis Seizures Asthma (severe)
Allergies Diabetes or any other serious or life-threatening condition

Public Health require us to hold full information on your child's condition to help keep them safe and well at school. We will require an up-to-date Action Plan from your GP before your child attends BIS. Please forward us a copy before their first day.

IN CASE OF ILLNESS, ACCIDENT OR EMERGENCY:

- 1) I give permission for my child to receive non-prescription medicines, e.g. Paracetamol/Panadol, Throat Lozenges.
- 2) If the School is unable to contact me, or if the accident/illness is serious, I understand that the school will take action on my behalf.

Signature: _____ Date: _____
 PARENT/ WHĀNAU/ GUARDIAN

LEARNING CONDITIONS (Supporting document must be supplied)

Has your child been diagnosed with any learning or behaviour conditions e.g. ADHD, Dyslexia, ASD?

Yes No

If yes please detail:

Describe any other special circumstances (learning or behavioural) the school should be aware of that may affect class work, sports or cultural activities:

