Howick Primary School

Student Enrolment Form

Willoughby Ave, Howick, Auckland. Phone (09) 534-6082 email:office@howickprimary.school.nz

STUDENT DETAILS

First Name(s) Legal: _____
(Including middle names)
Preferred First Name *(If different from above)* _____

Surname (Legal): _____

Preferred Surname *(If different from above)* _____

Home Address: _____

Date of Birth: *(dd/mm/yy)* _____ **Gender**: _____

Ethnicity: _____
(eg, NZ European, Maori, Chinese etc)

Country of Birth: _____

NZ Citizen Yes / No
NZ Resident Yes / No (copy of visa required)

Date of Entry to NZ: _____ *(dd/mm/yy)*

All Languages spoken: _____
(eg, Mandarin, Cantonese Afrikaans etc)

Permissions:

Attend Bible? ☐ Yes ☐ No

Publish student's images electronically? ☐ Yes ☐ No

We need: ☐ NZ Birth Certificate or ☐ NZ Passport or ☐ Passport and Visa

For Office Use only:

Start Date: _____

NSN: _____
ENROL: ☐

DOB Verification/Visa: Yes / No
Immunisation: Yes / No
Completed BYOD/Digital Form: Yes / No
Completed EOTC Form: Yes/No
Additional Information:

Enrolment Confirmation Letter:
_____

Year Level: _____

Room: _____

Teacher: _____

Whanau: _____
Birth date verification:
Birth Certificate Number:

Passport Number:

SF: *Letter:*

PARENT/GUARDIAN DETAILS

Parent A/Guardian:
☐ Lives with?

Title _____ Name: _____ Occupation: _____

If not Parent, please indicate relationship: _____

Home address: _____

Phone: (Home): _____ Phone: Work: _____
Email: _____ Mobile: _____

Parent B/Guardian:
☐ Lives with?

Title _____ Name: _____ Occupation: _____

If not Parent, please indicate relationship: _____

Home address: _____

Phone: (Home): _____ Phone: Work: _____
Email: _____ Mobile: _____

Emergency Contacts:

☐ Please use same as siblings

Name:_____ Name: _____

Phone: _____ Phone: _____

Relationship: _____ Relationship: _____

（尽量可以听懂并且讲英语）

CUSTODY ACCESS

Court orders issued? Yes / No / NA Attach further information as required.

HEALTH RECORD

Name of Family Doctor: _____ ***Phone***: _____

Medical Conditions: _____ Medication:_____

Sight/Vision/Speech/Hearing: _____

PREVIOUS SCHOOLING (INCLUDING EARLY CHILDHOOL EDUCATION)

Student is transferring from which School/ Kindergarten (Name)?: _____

Year Level: _____ Date Started School (if known): _____

Please indicate any Early Childhood education this student has received (if just starting school this year)

☐ Kohanga Reo
☐ Playcentre
☐ Kindergarten or Early Childhood Education Centre
☐ Home Based Service
☐ Attended, but only outside New Zealand
☐ Did not attend any service

Was ECE regularly attended?
☐ Yes, for the last _____ year/s
☐ Not regularly, only occasionally

Approx number of hours per week _____

ETHNIC GROUPS

Please choose up to three Ethnic Groups which you feel your child belongs to:

☐ New Zealand European

☐ New Zealand Maori – Please indicate iwi Affiliation
1. _____
2. _____

☐ Other European _____

☐ Pacific Islands (specify) _____

☐ Asian (specify) _____

☐ Other (specify) _____

LEARNING AND BEHAVIOUR

Learning/Behaviour Needs:

(Does your child see anyone from the Ministry, speech therapy, or hearing etc)

(History/current) Specialist Needs/Doctor/ORS/Early Intervention MOE Special Education:

_____

Name of Caseworker (add previous/current) :_____

Medical Diagnosis : _____

Has your child been stood down, suspended or excluded from another school? ☐ Yes ☐ No

If yes, what was the reason? _____

SIBLING/S CURRENTLY ATTENDING THIS SCHOOL

☐ Yes ☐ No If yes:

1. Name: _____ Room No: ___ 2. Name: _____ Room No: ___

DETAILS OF PRE-SCHOOLERS LIKELY TO BE ATTENDING THIS SCHOOL IN THE FUTURE

1. Name: _____ Birth Date: _____

2. Name: _____ Birth Date: _____

PARENT/CAREGIVER DECLARATION

I/We acknowledge that the information is true and correct in every particular and will be relied upon by the School.

I/We agree that our child shall abide by all School Rules and Regulations.

I/We understand the need to pay school costs.

I/We understand and give permission for the medication detailed in the Health Record list to be administered if, and when, necessary by the staff of Howick Primary School. If our child requires short term medication, eg, cough syrup/antibiotics, I/We will complete a medication request form at the office, which gives the school staff permission to administer this medication, the reason for the medication and will ensure the container is clearly labelled with the child's name, the contents of the container, the dosage, expiry date and other relevant information (eg, store in fridge). In the event of an accident or sudden illness, I/We authorise the staff of Howick Primary School to obtain such medical assistance as may be necessary.

I/We understand that my child's work and images may be used in accord with the school's e-learning procedure.

I/We understand that the information on this from will be used by HPS to maintain appropriate school records and effective contact with the enrolled pupil's parents/caregivers.

I/We also agree to the school requesting relevant information from other schools and from the Ministry of Education, for enrolment purposes and class placements and to forwarding relevant information to another school for enrolment purposes and class placements.

Privacy Statement: This information collected will be used by the school for enrolment and forms an essential part of the information held by the school on your child. The records made from this information may be viewed on request at the school. The information may be disclosed to appropriate education, health and welfare authorities and for data-gathering purposes by the New Zealand Ministry of Education, in accordance with the principles of the Privacy Act. It will not be disclosed to any other person or agency unless such disclosure is authorised or required by law.

Signature: _____ Date: _____