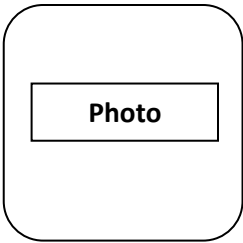




The Ela Murray International School  
Application for Enrolment  
Ela Beach Early Learning Centre



Date of application: \_\_\_\_\_

Date of commencement: \_\_\_\_\_

**Student Information**

Surname:		Year of entry	Grade
First name/s:			
Preferred first name:		DOB:	
Sex:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Language spoken at home:
Family situation: Child lives with:			
Place in family:		Nationality:	Religion:

**Placement**

			Mon	Tues	Wed	Thu	Fri
	Toddlers (from 18 months)	8:00-2:30					
	Reception (3 before March 31)	8:00-2:30					
	Transition (4 before March 31)	8:00-2:30					

**Siblings Name**

Siblings Name	Date of Birth	Grade(if at school)

**Home Address**

Street address:

Suburb

Home phone:

**Postal Address:**

**Emergency Information**

Contact 1 Name:		Contact 2 Name:	
Hm Ph:	Wk Ph:	Hm Ph:	Wk Ph:
Mobile:		Mobile:	

**Student's Doctor**

Name:	Phone:
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Mother/Guardian Details	Father/Guardian Details
Name:	Name:
Address: (if different from above)	Address: (if different from above)
Work phone:	Work phone:
Home phone:	Home phone:
Mobile:	Mobile:
Email:	Email:
Nationality:	Nationality:
Occupation:	Occupation:

Fee Information		
Fee payer:	Self <input type="checkbox"/>	Employer: <input type="checkbox"/> Name:
Method of sending invoice:	Fax: <input type="checkbox"/> Number:	Email: <input type="checkbox"/> Address:
Payment Type:	Annual: <input type="checkbox"/>	Term: <input type="checkbox"/>

Previous preschool Information (please attach reports and supporting documentation)
<p><b>Name and contact details of previous pre-school/day-care facility:</b></p>     <p>I / We give permission for The Ela Murray School to contact your previous pre-school or day-care Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Signature of parent or guardian _____</p> <p><b>(Please note that refusal to give permission may affect acceptance of enrolment?)</b></p>

Health and Safety
Does your child have any medical conditions that the school should be aware of? Yes <input type="checkbox"/> No <input type="checkbox"/> Nature of condition:
Does your child require any medication? Yes <input type="checkbox"/> No <input type="checkbox"/> Details of medication:



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**Special Needs**

This application gives the opportunity to provide information that will facilitate the transition of your child into our school. It will assist us to develop strategies to meet the particular needs of your child. As specialist or support services are not available in PNG, the Board of Governors may refuse enrolment in the best interests of your child.

Any reports, assessments, supporting or relevant documents relating to your child must be made available to the school prior to acceptance of enrolment

***If the information provided is incomplete or misleading, any decision made as to enrolment may be revised.***

**Has your child been diagnosed with, or shows signs of:**

autism/Asperger's <input type="checkbox"/>	behaviour disorders <input type="checkbox"/>	a hearing impairment <input type="checkbox"/>
an intellectual disability <input type="checkbox"/>	a language disorder <input type="checkbox"/>	mental health issues <input type="checkbox"/>
a physical disability <input type="checkbox"/>	a vision impairment <input type="checkbox"/>	ADD / ADHD <input type="checkbox"/>
giftedness <input type="checkbox"/>	difficulties in basic learning areas <input type="checkbox"/>	acquired brain injury <input type="checkbox"/>

other (please specify)

**What accommodations and/or learning adjustments, if any, were provided for your child in his/her previous school/pre-school?**

alternative teaching and learning strategies <input type="checkbox"/>	signing <input type="checkbox"/>
braille <input type="checkbox"/>	a reader or scribe <input type="checkbox"/>
access to technology <input type="checkbox"/>	personal carer support <input type="checkbox"/>
modifications -equipment, furniture, learning spaces <input type="checkbox"/>	other (please specify)

**Does your child need support from any of the following?**

speech therapist <input type="checkbox"/>	occupational therapist <input type="checkbox"/>
physical therapist <input type="checkbox"/>	other (please specify) <input type="checkbox"/>

Does your child have behaviour issues that may impact on the learning of others? Yes  No

Please provide details

