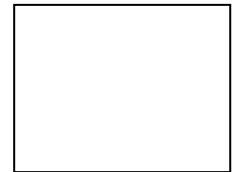




# GALSTAIN COLLEGE

5 Chiltern Road  
 INGLESIDE NSW 2101  
 Tele : 9970 6984 Fax : 9970 6778 E-mail : admin@hasg.nsw.edu.au



## GALSTAIN COLLEGE ENROLMENT FORM

### OFFICE USE ONLY

Student Code:  
 Family Code:  
 Year Commenced:

Name of Student:

Family Mailing Details		
Family Surname		
Mail to [eg Mr & Mrs Smith]		
Address	Suburb/City	Post Code
Home Phone Number	Other	
Dialect spoken: Western <input type="checkbox"/> Eastern <input type="checkbox"/> (please tick box)		

Student Details	
First Name	Commencement Year or Date
Middle Name	1 <sup>st</sup> Australian School Year (eg: 2001):
Surname	Previous School <span style="float: right;">Year Level</span>
Preferred Name	Religion
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female (please tick one)	Nationality
Country of Birth	Does the student speak a language(s) other than English at home? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes <input checked="" type="checkbox"/> Please List Below:
Date of Birth	1. <span style="float: right;">2.</span>
Present Year eg: Kinder, Year 7	3. <span style="float: right;">4.</span>

### PLEASE FILL IN THIS PART – IF APPLICABLE

Visa Student - Is the Student a Visa Student? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Residence Status: <input type="checkbox"/> Permanent <input type="checkbox"/> Non Permanent <input type="checkbox"/> Refugee	Visa Sub Class
Date of Arrival in Australia	Visa Number
Passport Number	Visa Expiry Date
OSHC Membership Number	OSHC Expiry Date
Confirmation of Date Enrolled at College:	Student in Year:
Confirmation of Enrolment Number	

Medical Details	
Doctor's Name	Phone Number
Student's Medicare Number	Date of Last Tetanus Injection/Booster
<b>Allergies / Medical Alert</b>	Please specify <b>any allergies/ medical alerts</b> relating to the student applying for enrolment (eg. Allergies to nuts, penicillin, bee stings etc; asthma management etc).
<b>Immunisations</b>	Has the Immunisation Certificate been submitted? Yes <input type="checkbox"/> No <input type="checkbox"/>

### Special Needs

Indicate whether the student attending College has any known or suspected **special needs** (please tick  Yes or No for each of the following)

Physical Needs Yes <input type="checkbox"/> No <input type="checkbox"/>	Medical Needs Yes <input type="checkbox"/> No <input type="checkbox"/>	Educational Needs Yes <input type="checkbox"/> No <input type="checkbox"/>	Behavioural Needs Yes <input type="checkbox"/> No <input type="checkbox"/>	Allergies Yes <input type="checkbox"/> No <input type="checkbox"/>	Any other special needs Yes <input type="checkbox"/> No <input type="checkbox"/>
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If you have answered yes to any of the above, please provide **full details** of those needs and any assessment/intervention/support that he/she may be currently receiving (**We have updated our medical records late last year. If these are recent cases of special needs, please request a Form to fill in these details, and return to us for our records.**)

### FAMILY CONTACT DETAILS

Details	Father or Guardian	Mother or Guardian
Title		
First Name		
Middle Name		
Surname		
Relationship		
Sex		
Address – Street		
Suburb & Post Code		
Residential Guardian Y/N?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Home Phone Number		
Work Phone Number		
Fax		
Mobile		
Email Address		
Occupation		
Are you <b>happy to assist the College in your work capacity</b> , relating to your occupation? i.e. if you work with or own a business that we could purchase services or goods from on behalf of the College.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Name of Employer		
Highest Year of School Education:	Year 12 or equivalent <input type="checkbox"/> Year 11 or equivalent <input type="checkbox"/> Year 10 or equivalent <input type="checkbox"/> Year 9 or equivalent or below <input type="checkbox"/>	Year 12 or equivalent <input type="checkbox"/> Year 11 or equivalent <input type="checkbox"/> Year 10 or equivalent <input type="checkbox"/> Year 9 or equivalent or below <input type="checkbox"/>
Level of Highest Qualification	Bachelor degree or above <input type="checkbox"/> Advanced Diploma/Diploma <input type="checkbox"/> Certificate I to IV (incl trade cert) <input type="checkbox"/> No non-school qualification <input type="checkbox"/>	Bachelor degree or above <input type="checkbox"/> Advanced Diploma/Diploma <input type="checkbox"/> Certificate I to IV (incl trade cert) <input type="checkbox"/> No non-school qualification <input type="checkbox"/>
Do you speak a language(s) other than English at home?	Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes <input checked="" type="checkbox"/> Please list below: 1. 2.	Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes <input checked="" type="checkbox"/> Please list below: 1. 2.
Country of Birth		
Nationality		
Religion		
<b>SIGNATURE</b>		

<b>OFFICE USE ONLY:</b> <b>Occupational Group</b>	Group 1	<input type="checkbox"/>	Group 1	<input type="checkbox"/>
	Group 2	<input type="checkbox"/>	Group 2	<input type="checkbox"/>
	Group 3	<input type="checkbox"/>	Group 3	<input type="checkbox"/>
	Group 4	<input type="checkbox"/>	Group 4	<input type="checkbox"/>

**PLEASE FILL IN THE INFORMATION BELOW, THANK YOU**

<b>EMERGENCY CONTACT DETAILS</b>		
<b>Details</b>	<b>Emergency Contact # 1</b>	<b>Emergency Contact # 2</b>
	If the emergency contact person is the Father, please list "Father, details above"	If the emergency contact person is the Mother, please list "Mother, details above"
Title		
First Name		
Surname		
Address - Street		
Suburb & Post Code		
Home Phone No.		
Business Phone No.		
Mobile Phone No.		
Email Address		
Relationship to Student		

<b>Children in at other Schools</b>				
<b>Please list below all children in the family attending other Schools or Colleges</b>				
	<b>Full Student Name</b>	<b>School Year</b>	<b>Birth Order</b>	<b>School Attending</b>
Child			1	
Child			2	
Child			3	
Child			4	