



ST BERNARD'S COLLEGE APPLICATION FOR ENROLMENT

Legal Surname: _____	YEAR LEVEL 2012 <i>(please circle)</i>
Preferred Surname: _____	7 8 9 10 11 12 13
Legal First Name: _____	Date of Birth: / / 19
Preferred First Name: _____	<i>(Ministry requirement: copy of student's birth certificate /passport attached)</i>
Middle Name(s): _____	
Home Address <i>(where student is living)</i>	Home Phone: _____
	Home Email: _____ <i>(parent/guardian email address)</i>
Postal Address <i>(if different from the above)</i>	

Previous School:	

Is this student under a stand down or suspension, or has he been expelled or excluded from his last school? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>(please tick)</i>	
Catholic Baptism: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(please tick)</i>	Confirmation: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(please tick)</i>
Which Catholic Parish is the family connected with OR if non-Catholic please state Religious affiliation (if any)	

PREFERENCE STUDENT <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(for office use only)</i> <i>(Principal)</i>	
ETHNICITY: <i>(please tick those applicable)</i>	
NZ European <input type="checkbox"/>	Other European <i>Please state</i> _____
NZ Maori <input type="checkbox"/>	Pacific Island <i>Please state</i> _____
Iwi Affiliation(s) <i>(please detail below)</i>	Asian <i>Please state</i> _____
_____	Other <i>Please state</i> _____
_____	Language spoken at home: _____
RESIDENCY STATUS <i>(please tick)</i>	
New Zealand/Australian Citizen	<input type="checkbox"/>
New Zealand/Australian Resident	<input type="checkbox"/>
Other <i>(please state)</i>	<input type="checkbox"/>
<i>If not born in New Zealand please provide evidence of eligibility to study in New Zealand (permanent residency or citizenship)</i>	

Parent(s) / Caregiver(s) at Home Address

Mr / Mrs / Miss / Ms / Dr <i>(please circle)</i>	Full Name	Relationship to student <i>(e.g. mother/father)</i>
Occupation	Employer	Work Contact Number: Mobile: Email:

Mr / Mrs / Miss / Ms / Dr <i>(please circle)</i>	Full Name	Relationship to student <i>(e.g. mother/father)</i>
Occupation	Employer	Work Contact Number: Mobile: Email:

Other Legal Guardian *(if applicable)*

Mr / Mrs / Miss / Ms / Dr <i>(please circle)</i>	Full Name	Relationship to Student
Phone(s) Home Work Mobile	Address	EXTRA COPY OF SCHOOL REPORT REQUIRED? Yes / No <i>(please circle)</i>

Emergency Contact *(when parent/caregiver is unavailable)*

Name	Phone: (Home):
Relationship to student:	(Work):
	(Mobile):

Any other information you consider relevant about your student?

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SIGNATURE AND DECLARATION *(To be completed by all applicants)*

I / We hereby agree to pay **ATTENDANCE DUES** as determined by the Catholic Schools Board Ltd and the various subject fees as determined by the Board of Trustees, including making the **COLLEGE RESOURCE DONATION**. I / We agree to ensure that this pupil will wear the **CORRECT COLLEGE UNIFORM**, and adhere to the **SCHOOL RULES** and **CODE OF CONDUCT** (details are provided in the Enrolment Pack). I / We accept as a condition of enrolment that this pupil will participate in the general College programme that gives St Bernard's College its Catholic character. I / We will be happy to assist where I / we can to belong to the College community. I / We authorise St Bernard's College to ask the previous school of this pupil for any relevant school records.

Parents'/Caregivers' signatures: **Dated**

All the information on this form is CONFIDENTIAL and is covered by the Privacy Act 1993. This information is held at St Bernard's College, 183 Waterloo Road, Lower Hutt and is available to the staff and members of the Board of Trustees of the College and to agencies working with the College for the benefit of students at the College.

STUDENT HEALTH INFORMATION *(Please complete and return)*

Surname: _____ **First Name/s:** _____

At St Bernard's College we wish to know of any health issue which may affect your son's attendance, learning and/or development. This information helps us to plan accordingly.
(Please circle any that are relevant)

Asthma

Skin

Mental Health

Hearing

Epilepsy

Drugs/alcohol

Vision/glasses

Allergies

Smoking

Behaviour

Headaches/migraine

Any other information:

Does your child/young person take any regular or emergency medicines?

Yes No *(please tick)*

Family Doctor's Name _____

Dentist _____

Any other health condition requiring emergency first aid care?

Yes No *(please tick)*

Details:
