

**Enrolment Site:**St Joseph's Flexible Learning Centre,  
North MelbourneSt Joseph's Flexible Learning Centre,  
GeelongSt Francis Flexible Learning Centre,  
Hobart

## FULL TIME STUDENT ENROLMENT FORM

### STUDENT DETAILS

<b>Surname:</b>											
<b>First Given Name:</b>											
<b>Second Given Name:</b>											
<b>Preferred Name (if applicable):</b>											
<b>* Gender:</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (please specify)					<b>Date of Birth:</b>	___/___/___				
<b>Student Mobile Number:</b>											
<b>Student Email Address:</b>											
<b>Victorian Student Number (VSN) (if known):</b> (Victorian Students Only)											
<b>Unique Student Identifier (USI) (if known):</b>											
<b>Religion:</b>											

### PRIMARY HOME ADDRESS

<b>Address:</b>										
<b>Suburb:</b>										
<b>State:</b>						<b>Postcode:</b>				
<b>Living Independently:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No									

### FAMILY DETAILS

<b>List any other family members who are attending this school or have attended this school in the past:</b>

\* This question is asked as a requirement of the Commonwealth Government. All schools across Australia are required to collect the same information.

#### OFFICE USE ONLY

<b>Copy of name and birth date evidence provided:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Entry Year Level:</b>	
<b>House (if applicable):</b>		<b>PC/Tutor Group:</b>	
<b>Enrolment date:</b>		<b>Enrolment meeting completed by:</b>	

## PRIMARY FAMILY DETAILS (PLEASE ENSURE THE DETAILS PROVIDED HERE ARE SUPPORTED BY THE FAMILY ARRANGEMENTS)

ADULT A DETAILS:	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (please specify)
Title (Ms, Mrs, Dr, Mr, etc):	
First Given Name:	
Surname:	
Relationship to student:	
Student lives with Adult A:	<input type="checkbox"/> Yes <input type="checkbox"/> No (if no, please complete address below)
Address:	
Suburb:	
State:	
Postcode:	
Mobile Phone No:	
Home Phone No:	
Work/Other Phone No:	
SMS Notifications:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address:	
What is Adult A's occupation?	
In which country was Adult A born?	<input type="checkbox"/> Australia <input type="checkbox"/> Other (please specify)
* Does Adult A speak a language other than English at home? (If more than one language is spoken at home, indicate the one that is spoken the most often.)	<input type="checkbox"/> No, English only <input type="checkbox"/> Yes (please specify)
* What is the highest year of school Adult A has completed? (For persons who have never attended school, mark '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
* What is the level of the highest qualification Adult A has completed?	<input type="checkbox"/> Bachelor's degree or above <input type="checkbox"/> Advanced diploma/Diploma <input type="checkbox"/> Cert I to IV (including trade certificate) <input type="checkbox"/> No non-school qualification

ADULT B DETAILS:	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (please specify)
Title (Ms, Mrs, Dr, Mr, etc):	
First Given Name:	
Surname:	
Relationship to student:	
Student lives with Adult B:	<input type="checkbox"/> Yes <input type="checkbox"/> No (if no, please complete address below)
Address:	
Suburb:	
State:	
Postcode:	
Mobile Phone No:	
Home Phone No:	
Work/Other Phone No:	
SMS Notifications:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address:	
What is Adult B's occupation?	
In which country was Adult B born?	<input type="checkbox"/> Australia <input type="checkbox"/> Other (please specify)
* Does Adult B speak a language other than English at home? (If more than one language is spoken at home, indicate the one that is spoken the most often.)	<input type="checkbox"/> No, English only <input type="checkbox"/> Yes (please specify)
* What is the highest year of school Adult B has completed? (For persons who have never attended school, mark '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
* What is the level of the highest qualification Adult B has completed?	<input type="checkbox"/> Bachelor's degree or above <input type="checkbox"/> Advanced diploma/Diploma <input type="checkbox"/> Cert I to IV (including trade certificate) <input type="checkbox"/> No non-school qualification

\* These questions are asked as a requirement of the Commonwealth Government. All schools across Australia are required to collect the same information.

### OFFICE USE ONLY

* Occupation group of Adult A (please select the appropriate code from the Parental Occupation Group Code list):		* Occupation group of Adult B (please select the appropriate code from the Parental Occupation Group Code list):	
---	--	---	--

## PRIMARY FAMILY DETAILS - CONTINUED

Is Adult A an emergency contact?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Send correspondence/newsletters to Adult A?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Send academic reports to Adult A?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Send attendance notifications to Adult A?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is Adult B an emergency contact?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Send correspondence/newsletters to Adult B?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Send academic reports to Adult B?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Send attendance notifications to Adult B?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## ADDITIONAL EMERGENCY CONTACTS

Order of Contact	First Name	Surname	Relationship (grandparent, aunt, friend, neighbour etc.)	Contact Number

## FAMILY ARRANGEMENTS AND CHILD PROTECTION

Is the student known to Child Protection Services?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Are there any parenting or Family Law orders in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Type of order (please provide copy of document):	<input type="checkbox"/> Family Law Court Order <input type="checkbox"/> Parenting Plan <input type="checkbox"/> Intervention Order <input type="checkbox"/> Child Protection Order		
Describe any access restrictions to the student:			
Type of Child Protection Order (please provide copy of document):	<input type="checkbox"/> Interim Accommodation Order (IAO) <input type="checkbox"/> Family Reunification Order (FRO) <input type="checkbox"/> Family Preservation Order (FPO) <input type="checkbox"/> Care by Secretary Order (CBSO) <input type="checkbox"/> Permanent Care Order (PCO) <input type="checkbox"/> Long Term Care Order <input type="checkbox"/> Voluntary Order		
Is the student in Out-of-home Care (OoHC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, what type of Care:	<input type="checkbox"/> Residential Care <input type="checkbox"/> Foster Care <input type="checkbox"/> Kinship Care <input type="checkbox"/> Permanent Care <input type="checkbox"/> Self-placed Care <input type="checkbox"/> State Care with Parents		
DHHS Manager Name:		DHHS Manager Phone No:	
Care/Case Manager Name:		Care/Case Manager Phone No:	
Guardianship of the student is with:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> DHHS Child Protection <input type="checkbox"/> Kinship (eg. aunt/grandfather) <input type="checkbox"/> Community Service Organisation (CSO)		
Care Start Date:	___ / ___ / _____	Care End Date:	___ / ___ / _____
Has the student previously been in OoHC?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Please provide details:			

### OFFICE USE ONLY

Has a copy of the parenting or Family Law Order been provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has a copy of the Child Protection Order been provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--	---	--

## DEMOGRAPHIC DETAILS OF STUDENT

* Country of Birth:	<input type="checkbox"/> Australia <input type="checkbox"/> Other (please specify)	
* Is the student of Aboriginal or Torres Strait Islander origin?	<input type="checkbox"/> No <input type="checkbox"/> Yes, Aboriginal	<input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> Yes, both Aboriginal & Torres Strait Islander
Cultural Background:	<input type="checkbox"/> New Zealander <input type="checkbox"/> Tongan <input type="checkbox"/> South Sudanese <input type="checkbox"/> Eritrean <input type="checkbox"/> Other African	<input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Ethiopian <input type="checkbox"/> Somalian <input type="checkbox"/> Other Cultural Background
* Does the student speak a language other than English at home?	<input type="checkbox"/> No, English only <input type="checkbox"/> Yes (please specify)	
Year of Arrival in Australia:		
ImmiCard Number:		
Passport Number:		
Passport Country of Issue:		

## PREVIOUS SCHOOL DETAILS

Date of first enrolment in an Australian school:	___ / ___ / _____		
Name of Previous School:			
Start Date:	___ / ___ / _____	Date of Leaving:	___ / ___ / _____
Year Levels Attended:			
Reason for Leaving:			
Year Levels Repeated (if applicable):			

## YOUTH JUSTICE INVOLVEMENT

Has the student had previous contact with the Justice System?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please provide details:			
Is the student currently involved in the Justice System?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Are there any current Orders or Conditions? (please provide copy of document)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please provide details:			
Youth Justice Case Worker:		Contact No:	

\* These questions are asked as a requirement of the Commonwealth Government. All schools across Australia are required to collect the same information.

### OFFICE USE ONLY

Copy of IMMI Card provided:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
VEVO Check Completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Check:	___ / ___ / _____
Visa Class/Subclass:		Visa Grant Date:	___ / ___ / _____
Visa Type:		Study Conditions:	
Has the previous school been contacted?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have any previous school documents been provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have any current Youth Justice Orders or Condition documents been provided?			<input type="checkbox"/> Yes <input type="checkbox"/> No

## MEDICAL DETAILS OF STUDENT

Medicare Card No:	<input type="text"/>	Individual Reference No:	<input type="text"/>
Medicare Expiry Date:	___ / ___	Medicare Card Name:	<input type="text"/>
Health Care Card CRN No:	<input type="text"/>	Health Care Card Expiry Date:	___ / ___
Practitioner 1 Type:	<input type="checkbox"/> General Practitioner (GP) <input type="checkbox"/> Psychologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Allergist/Immunologist <input type="checkbox"/> Pediatrician <input type="checkbox"/> Other (please specify)		
Practitioner 1 Name:	<input type="text"/>	Practitioner 1 Phone No:	<input type="text"/>
Practitioner 2 Type:	<input type="checkbox"/> General Practitioner (GP) <input type="checkbox"/> Psychologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Allergist/Immunologist <input type="checkbox"/> Pediatrician <input type="checkbox"/> Other (please specify)		
Practitioner 2 Name:	<input type="text"/>	Practitioner 2 Phone No:	<input type="text"/>
Do you give permission for paracetamol, antihistamine tablets, Ventolin, bandages and band aids to be administered at school if needed?			<input type="checkbox"/> Yes <input type="checkbox"/> No

## MEDICAL CONDITIONS

Does the student experience any of the following conditions? In details, please include frequency, triggers, symptoms, treatment and medication information.			
<b>Allergies</b> (if yes, please provide completed Action Plan for Allergic Reactions completed by GP/hospital)	<input type="checkbox"/> No <input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Details:	<input type="text"/>
<b>Anaphylaxis</b> (if yes, please provide completed ASCIA Anaphylaxis Management Form completed by GP/hospital)	<input type="checkbox"/> No <input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Details:	<input type="text"/>
<b>Asthma</b> (if yes, please provide completed Asthma Management Form completed by GP/hospital)	<input type="checkbox"/> No <input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Details:	<i>If yes, please complete Asthma Medical Condition Details below.</i>
<b>Blackouts</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Details:	<input type="text"/>
<b>Cardiac/Heart Conditions</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Details:	<input type="text"/>
<b>Diabetes</b> (if yes, please provide completed Diabetes Action and Management Plan completed by GP/hospital)	<input type="checkbox"/> No <input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Details:	<input type="text"/>
<b>Dizziness/Dizzy Spells</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Details:	<input type="text"/>
<b>Epilepsy</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Details:	<input type="text"/>
<b>Fits or Non-Epileptic Seizures</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Details:	<input type="text"/>
<b>Migraines</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Details:	<input type="text"/>
<b>Nutritional Concerns</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Details:	<input type="text"/>
<b>Other Illness</b> (please specify)	<input type="checkbox"/> No <input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Details:	<input type="text"/>
<b>Other Illness</b> (please specify)	<input type="checkbox"/> No <input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Details:	<input type="text"/>

### OFFICE USE ONLY

Copy of Medicare Card provided:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Copy of Health Care Card provided:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has a completed Action Plan for Allergic Reactions been provided? (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has a completed ASCIA Anaphylaxis Management Form been provided? (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has a completed Asthma Management Form been provided? (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has a completed Diabetes Action and Management Plan been provided? (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No

## ASTHMA MEDICAL CONDITION DETAILS

Answer the following questions <u>ONLY</u> if the student suffers from any Asthma medical conditions.			
The student suffers from the following symptoms (select all that apply):		<input type="checkbox"/> Cough	<input type="checkbox"/> Difficulty breathing
		<input type="checkbox"/> Wheeze	<input type="checkbox"/> Exhibits symptoms after exertion
		<input type="checkbox"/> Tight Chest	<input type="checkbox"/> Difficulty in speaking
Does the student take medication?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of medication:			
Dosage of medication:		How frequently is the medication taken?	
Medication is to be administered by:		<input type="checkbox"/> Student <input type="checkbox"/> School Staff <input type="checkbox"/> Other (please indicate)	
Medication is stored:		<input type="checkbox"/> With Student <input type="checkbox"/> With School Administration	
Dosage time/s:		Reminder required?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## MEDICAL CONDITIONS - CONTINUED

Does the student experience any of the following conditions? For each condition, complete the Medical Condition Details section below.			
<b>Behavioural Concerns</b> – for example, ADHD (Attention Deficit Hyperactivity Disorder), Conduct Disorder, ODD (Oppositional Defiance Disorder, etc.			
Please specify:	<input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Has this condition been diagnosed? (if yes, please provide copy of diagnoses documents and additional care plans)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please specify:	<input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Has this condition been diagnosed? (if yes, please provide copy of diagnoses documents and additional care plans)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Developmental/Learning Needs and Concerns</b> – for example, ASD (Autism Spectrum Disorder), Intellectual Disability, etc			
Please specify:	<input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Has this condition been diagnosed? (if yes, please provide copy of diagnoses documents and additional care plans)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please specify:	<input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Has this condition been diagnosed? (if yes, please provide copy of diagnoses documents and additional care plans)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Mental Health Concerns</b> – for example, Anxiety Disorders, Mood Disorders (including Depression), Personality Disorders, etc.			
Please specify:	<input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Has this condition been diagnosed? (if yes, please provide copy of diagnoses documents and additional care plans)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please specify:	<input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Has this condition been diagnosed? (if yes, please provide copy of diagnoses documents and additional care plans)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Physical Health Concerns</b> – for example, Acquired Brain Injury, Sleep Disorder, etc.			
Please specify:	<input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Has this condition been diagnosed? (if yes, please provide copy of diagnoses documents and additional care plans)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please specify:	<input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Has this condition been diagnosed? (if yes, please provide copy of diagnoses documents and additional care plans)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Sensory Impairments</b> – for example, Hearing Impairment, Mobility Impairment, Pain Disorders, etc.			
Please specify:	<input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Has this condition been diagnosed? (if yes, please provide copy of diagnoses documents and additional care plans)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please specify:	<input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Has this condition been diagnosed? (if yes, please provide copy of diagnoses documents and additional care plans)	<input type="checkbox"/> Yes <input type="checkbox"/> No

## MEDICAL CONDITION DETAILS

Name of Medical Condition 1 (please indicate from the above table):			
Please describe the frequency, triggers, symptoms, treatment and actions required to be taken:			
Does the student take medication?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of medication:			
Dosage of medication:		How frequently is the medication taken?	
Medication is to be administered by:		<input type="checkbox"/> Student <input type="checkbox"/> School Staff <input type="checkbox"/> Other (please indicate)	
Medication is stored:		<input type="checkbox"/> With Student <input type="checkbox"/> With School Administration	
Dosage time/s:		Reminder required?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Medical Condition 2 (please indicate from the above table):			
Please describe the frequency, triggers, symptoms, treatment and actions required to be taken:			
Does the student take medication?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of medication:			
Dosage of medication:		How frequently is the medication taken?	
Medication is to be administered by:		<input type="checkbox"/> Student <input type="checkbox"/> School Staff <input type="checkbox"/> Other (please indicate)	
Medication is stored:		<input type="checkbox"/> With Student <input type="checkbox"/> With School Administration	
Dosage time/s:		Reminder required?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## ADDITIONAL HEALTH CONCERNS

Does the student suffer from any of these conditions? In details, please include type, frequency, triggers, symptoms, treatment and medication information.			
Substance Use (please specify type):	<input type="checkbox"/> No <input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Details:	
Self-Harm	<input type="checkbox"/> No <input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Details:	
Suicidal thoughts and intentions	<input type="checkbox"/> No <input type="checkbox"/> Yes, mild <input type="checkbox"/> Yes, severe	Details:	

### OFFICE USE ONLY

Has a copy of the diagnoses and additional care plans for each medical condition been provided? (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If medication/s are to be administered at school and stored in the school administration area, a Consent to Administer Medication to Student form will need to be completed, signed and stored with the medication. Has this been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## WELLBEING & SOCIAL BACKGROUND

Is the student a parent or expecting?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Name/s and age/s of the child/ren or due date of birth?	
Are there any issues caring for the child/ren?	<input type="checkbox"/> No <input type="checkbox"/> Yes (please specify)
Is DHHS involved with the wellbeing of the child/ren?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does the student have any family relationship issues?	<input type="checkbox"/> No <input type="checkbox"/> Yes (please specify)
Has the student been exposed to violence and/or trauma?	<input type="checkbox"/> No <input type="checkbox"/> Yes (please specify)
Does the student participate in any risk-taking behaviours?	<input type="checkbox"/> No <input type="checkbox"/> Yes (please specify)



# PARENT/GUARDIAN ENROLMENT AGREEMENT

I/We, being the parent(s)/guardian(s) of the young person to be enrolled or the young person if over 18, accept the offer of a place at St. Joseph's Flexible Learning Centre, North Melbourne or Geelong or St. Francis Flexible Learning Centre, Hobart.

In accepting this offer, I/we accept the following terms. I/we understand that should these terms not be acceptable to me/us, the young person may not be able to participate in some programs or activities. I/we understand that any concerns I/we have about these terms may be discussed with a school staff member and I/we may provide comments below.

## TERMS

1. I/we will work with staff of the Flexible Learning Centre (FLC) to support the young person to regularly attend the program in school times and achieve their goals. I/we understand and accept that the program runs full time from Monday to Friday.
2. I/we understand and accept that the young person is not allowed on campus outside of program times unless pre-arranged and accompanied by a staff member.
3. I/we understand and will support the young person to operate within the school's four important principles:
  - RESPECT,
  - PARTICIPATION (having a go),
  - SAFE AND LEGAL, and
  - HONESTY.
4. I/we understand and accept that if the young person cannot or chooses not to operate within the principles then they may be asked to participate in an alternate activity or go home for the day.
5. I/we understand and accept that if the young person chooses to leave campus or is asked to go home for the day, the young person may have to make their own way home without staff supervision. I/we understand that if this occurs when the young person is on an excursion, the staff member will ensure that the young person has money for public transport to travel home unsupervised. The staff member will also contact a parent or guardian.
6. I/we understand and accept that school staff have the authority to make decisions in relation to the safety and conduct of the young person while they are attending the program.
7. I/we understand and accept that I/we may be asked to support the young person to participate in meetings to work through any concerns or support needs relating to the young person.
8. I/we understand that the FLC does not suspend or expel young people. I/we understand and accept that the FLC asks young people to make a commitment to operate within the principles. However, if the young person is not able or chooses not to operate within the principles during the normal school program, staff may be required to work in alternative ways with the young person until such time as they can operate within the principles. This may include working with the young person offsite or on an individual timetable.
9. I/we consent for the young person to travel in a FLC vehicle or in any form of public or private transport deemed necessary by the FLC, for example to attend an excursion or in the case of an emergency.
10. I/we consent for the young person to take part in staff supervised class excursions that may include visits to a local park, local library, swimming at a pool, etc. I/we understand that a separate consent form will be sent to us should the young person choose to participate in any 'high-risk' activities, extended excursions or camps.
11. I/we understand and accept that no fees are charged to attend the FLC, therefore, I/we agree to support the school to access funding for the young person through the completion of forms or provision of information, as requested.
12. I/we undertake to attend school meetings and events and assist with any other support or information required by the school staff to support the young person.
13. I/we undertake to provide the school with all relevant information relating to the young person's health and any medical conditions.
14. I/we understand and accept that in an emergency it may not always be possible to readily contact a parent, guardian or carer. In this case the staff member will take reasonable care of a young person suffering from an accident or illness but will not be responsible for the costs of any ambulance, medical, dental attention or any other treatment or services

administered to the student. Additionally, the FLC will not be responsible directly or indirectly for any act or omission of any medical or dental practitioner or other treating personnel attending to the young person.

15. I/we undertake to contact the school staff as soon as possible if the young person is to leave the program.
16. I/we understand and accept that the word 'Principal' includes any staff members carrying out the duties of, or exercising the authority of, the Principal.
17. The FLC administers young people support programs. These are voluntary programs. I/we consent to these programs if the young person chooses to participate.
18. I/we give permission for the image (photo) of the young person to be used in the school database and on concession/ID cards.
19. I/we give additional permission for the following:
  - Use of **photos only** for school publications viewed mainly by our school community, including the annual yearbook.  Yes  No
  - Use of **videos only** for school publications viewed mainly by our school community.  Yes  No
  - Use of **photos and videos** for school publications viewed mainly by our school community, including the annual yearbook.  Yes  No

## DECLARATION

Thank you for taking the time to complete this **Student Enrolment Form**. We understand that the information you have provided is confidential and will be treated as such, but the details are required to enable staff to properly enrol the student at our school.

I certify that the information contained within this form is correct.

First Parent/Guardian Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Second Parent/Guardian Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Comment (if any): \_\_\_\_\_

\_\_\_\_\_

### Campus Principal/Head of Campus Signature

I accept the above-named young person for participation at St. Joseph's Flexible Learning Centre, North Melbourne or Geelong or St. Francis Flexible Learning Centre, Hobart.

Campus Principal/Head of Campus Name: \_\_\_\_\_

Campus Principal/Head of Campus Signature: \_\_\_\_\_

Date: \_\_\_\_\_