



# Manurewa East School

## Enrolment form

Enrolment #

Start Date

Year

Room

### STUDENT INFORMATION

Last Name		First Name(s)		Preferred Name		Gender
Address			Suburb	Post Code	Interested in Maori Bilingual?	
Phone		Cell Phone			Email Address	
Date of Birth	Eldest?	Only?	Last School or Preschool	ECE Hours per week	NSN	
Ethnicity		First language		Country of Origin		Date entered NZ
Doctor		Doctor's Address				Doctor's Phone
Medical Notes - problems, allergies, medication, disability information						

### PARENT/CAREGIVER INFORMATION

Mr/Mrs/Miss	First Name	Last Name		Relationship to student
Address (if different from student)			Suburb	Phone
Occupation	Employer	Business phone	Cell phone	

### PARENT/CAREGIVER INFORMATION

Mr/Mrs/Miss	First Name	Last Name		Relationship to student
Address (if different from student)			Suburb	Phone
Occupation	Employer	Business phone	Cell phone	

Names of Legal Guardians
Custody Arrangements/Access Restrictions

Birth certificate .....	<b>OFFICE USE ONLY</b>	Permissions granted .....1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
Immunisation certificate .....		Entered on eTap .....
.....		Entered on ENROL .....
.....		Invoice created .....

**ETHNICITY AND LANGUAGE**

Father's Ethnicity	Mother's Ethnicity	Iwi
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**EMERGENCY CONTACTS**

Name	Relationship to student	Address	Phone
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Name	Relationship to student	Address	Phone
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Name	Relationship to student	Address	Phone
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**FAMILY MEMBERS CURRENTLY ATTENDING THIS SCHOOL:**

Name	Room
------	------

Name	Room
------	------

Name	Room
------	------

I undertake to see that \_\_\_\_\_ attends school regularly, wears the correct school uniform and follows the school rules and regulations as set by the Board of Trustees. I also give permission for the information contained in this enrolment form and the student's attainment records to be made available to other educational and support agencies.

**Please notify the school of any legal access restrictions to the student.**

Signature of Parent/Caregiver \_\_\_\_\_

Date \_\_\_\_\_



# Manurewa East School

**KORE MAHI KORE KAI**

Office: 09-2669487  
office@manurewaeast.school.nz  
www.manurewaeast.school.nz  
10 Scotts Road, Manurewa, Auckland 2102

## School Permission Form

Permission is needed for various school activities. Please circle your response to each statement and return it to school.

### I give permission for:

- |          |  |
|----------|--|
| Yes / No | My child to go on official school trips. I know I will always be notified of these, however I give permission to attend if I am unable to be contacted.                            |
| Yes / No | My child's photograph/video to be used for school publicity including school websites, school brochure and newspapers.   |
| Yes / No | My child to use school email and internet facilities under teacher supervision, with limited internet access to recognised safe sites.   |
| Yes / No | My child's work to be published on the school's internet website, the local newspaper or a school publication. Student surnames will not be added to any published work or images. |

**I understand that I may withdraw permission at any time for any of the above items.**

### Please note that:

- Any information collected or provided on your child will be used to assist your child, and will be used according to the provisions of the Privacy Act 1993.
- Student surnames, home addresses and phone numbers will NOT be available on the school website.
- Under no circumstances will 'chat rooms' be entered.

Student Name: .....

Parent/Caregiver Signature: .....

Date: .....

PARENT / GUARDIAN CONSENT FOR EXAMINATION, XRAY  
CLEANING, AND PREVENTIVE CARE.

Child's First Name  Child's Middle Name(s)

Child's Family Name (Last Name)  Also Known As

Male ☐ Female ☐

Child's Date of Birth  day  month  year

Street Address, including suburb and postcode if known

Home Phone  Work Phone  Mobile Phone (Parent/Guardian)

Email Address (Parent/Guardian)

Brother's / Sister's Name/s and Date of Birth

Name	DOB
<input type="text"/>	<input type="text"/>
Name	DOB
<input type="text"/>	<input type="text"/>
Name	DOB
<input type="text"/>	<input type="text"/>

Medical Practice / Centre Attended

Ethnicity  
Which ethnic group does this child belong to?  
Tick the space or spaces that apply

Current School / Preschool

Is your child eligible to receive free health care in the NZ public health system?  
Yes ☐ No ☐ Don't know ☐

☐ New Zealand European ☐ Māori ☐ Fijian ☐ Samoan ☐ South East Asian ☐ Cook Island Maori ☐ Middle Eastern ☐ Tongan ☐ Latin American / Hispanic ☐ Niuean ☐ Chinese ☐ African ☐ Indian ☐ Tokelauan ☐ Other (Such as Dutch, Japanese etc.)

For information on eligibility please visit  
www.moh.govt.nz/eligibility or contact 0800 825 583

Please state:

If you want your child to be seen by the Auckland Regional Dental Service please complete and sign the GREEN agree sections

If you DO NOT want your child to be seen by the Auckland Regional Dental Service please complete and sign the ORANGE do not consent sections

MEDICAL HISTORY

Some medical conditions and some medicines can affect dental care. To help us take good care of your child and ensure their safety please let us know if your child has or is suffering from any of the following:

Rheumatic Fever	Yes <input type="radio"/> No <input type="radio"/>	Asthma	Yes <input type="radio"/> No <input type="radio"/>
Heart Conditions	Yes <input type="radio"/> No <input type="radio"/>	Epilepsy	Yes <input type="radio"/> No <input type="radio"/>
Bleeding Conditions	Yes <input type="radio"/> No <input type="radio"/>	Latex Allergy (rubber)	Yes <input type="radio"/> No <input type="radio"/>

Other Conditions/Allergies

Medications

Currently Taking

CONSENT FOR SERVICES PROVIDED



I **AGREE** to this child receiving regular:

- Examinations and dental xrays as required
- Cleaning and scaling
- Fissure Sealant
- Fluoride Varnish

I understand that I have the right to change this consent at any time.  
Please ring **0800 TALKTEETH (0800 825 583)**

**Any additional treatments will require further consent.**

Comments

Print Family Name (Parent/Guardian)

Today's Date  day  month  20 year

Print First name (Parent/Guardian)

Signature (Parent/Guardian if under 16yrs)  Relationship to Child:

DO NOT CONSENT (DO NOT AGREE)



I **DO NOT AGREE** to this child receiving dental services from the Auckland Regional Dental Service.

Print Family Name (Parent/Guardian)

Today's Date  day  month  20 year

Print First name (Parent/Guardian)

Signature (Parent/Guardian if under 16yrs)  Relationship to Child: