



## ENROLMENT FORM

**Term:** 1 / 2 / 3 / 4 please circle

**Contact Details:**

Family Name:..... Drivers Licence No ..... Name on Licence.....  
 Mother:..... Father:.....  
 Mobile No:..... Mobile No:.....  
 Person enrolling this Student/Relationship:.....  
 Address:.....  
 Town: ..... Postcode:.....  
 Home Phone:..... Fax:.....  
 Email:.....

**Student Details:**

Name:.....  
 Date of Birth:.....  
 Medical Conditions: Please complete the following information so that staff can plan for your child's safety in the water

<input type="checkbox"/> Asthma	<input type="checkbox"/> Excessive fear of water	<input type="checkbox"/> Is your child under a health plan (attach)
<input type="checkbox"/> Heart Disorder	<input type="checkbox"/> Severe allergy	<input type="checkbox"/> Hearing impairment
<input type="checkbox"/> Joint Disorder (Arthritis)	<input type="checkbox"/> Skin Condition	<input type="checkbox"/> Vision Impairment
<input type="checkbox"/> Communication Difficulties	<input type="checkbox"/> Ear Disorder (grommets)	<input type="checkbox"/> Seizures
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Coordination Difficulties	<input type="checkbox"/> Other (Please give details)
<input type="checkbox"/> Is your child on medication	<input type="checkbox"/> Diabetes	

Other:.....  
 .....

Is your child currently enrolled at School?                      Yes / No    Please circle  
 If so, School Attending:.....  
 Other Siblings Yes / No    Please circle  
 Enrolled:                      Yes / No    Please circle

**Please complete details of other children enrolled on the reverse of this page**

**Emergency Contact Details:**

We require an **Emergency contact number** of someone other than the main carer (ie Neighbour/Grandparent). At times it may be necessary to contact this person should the main carer require 1<sup>st</sup> Aid etc.

Name:.....  
 Address:.....  
 Phone Home:..... Mobile:.....

*We appreciate your Privacy and **all** information gathered will be held in the strictest of Confidence. Please understand that relevant medical details may need to be shared with Staff members in order to ensure the safety of your child and others.*

How did you hear about EDGE Aquatics? Please circle or inform  
 Newspaper                      Friends                      Flyer                      Other.....



## ENROLMENT FORM

### **Other students enrolled at EDGE Aquatics**

**Student Details:**

Name:.....

Date of Birth:.....

Medical Conditions: Please complete the following information so that staff can plan for your child's safety in the water

<input type="checkbox"/> Asthma	<input type="checkbox"/> Excessive fear of water	<input type="checkbox"/> Is your child under a health plan (attach)
<input type="checkbox"/> Heart Disorder	<input type="checkbox"/> Severe allergy	<input type="checkbox"/> Hearing impairment
<input type="checkbox"/> Joint Disorder (Arthritis)	<input type="checkbox"/> Skin Condition	<input type="checkbox"/> Vision Impairment
<input type="checkbox"/> Communication Difficulties	<input type="checkbox"/> Ear Disorder (grommets)	<input type="checkbox"/> Seizures
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Coordination Difficulties	<input type="checkbox"/> Other (Please give details)
<input type="checkbox"/> Is your child on medication	<input type="checkbox"/> Diabetes	

Other:.....  
 .....

Is your child currently enrolled at School?                      Yes / No                      Please circle

If so, School Attending:.....

**Student Details:**

Name:.....

Date of Birth:.....

Medical Conditions: Please complete the following information so that staff can plan for your child's safety in the water

<input type="checkbox"/> Asthma	<input type="checkbox"/> Excessive fear of water	<input type="checkbox"/> Is your child under a health plan (attach)
<input type="checkbox"/> Heart Disorder	<input type="checkbox"/> Severe allergy	<input type="checkbox"/> Hearing impairment
<input type="checkbox"/> Joint Disorder (Arthritis)	<input type="checkbox"/> Skin Condition	<input type="checkbox"/> Vision Impairment
<input type="checkbox"/> Communication Difficulties	<input type="checkbox"/> Ear Disorder (grommets)	<input type="checkbox"/> Seizures
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Coordination Difficulties	<input type="checkbox"/> Other (Please give details)
<input type="checkbox"/> Is your child on medication	<input type="checkbox"/> Diabetes	

Other:.....  
 .....

Is your child currently enrolled at School?                      Yes / No                      Please circle

If so, School Attending:.....

**Student Details:**

Name:.....

Date of Birth:.....

Medical Conditions: Please complete the following information so that staff can plan for your child's safety in the water

<input type="checkbox"/> Asthma	<input type="checkbox"/> Excessive fear of water	<input type="checkbox"/> Is your child under a health plan (attach)
<input type="checkbox"/> Heart Disorder	<input type="checkbox"/> Severe allergy	<input type="checkbox"/> Hearing impairment
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<input type="checkbox"/> Communication Difficulties	<input type="checkbox"/> Ear Disorder (grommets)	<input type="checkbox"/> Seizures
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Coordination Difficulties	<input type="checkbox"/> Other (Please give details)
<input type="checkbox"/> Is your child on medication	<input type="checkbox"/> Diabetes	

Other:.....

Is your child currently enrolled at School? Yes / No Please circle

If so, School Attending:.....