



XAVIER CATHOLIC COLLEGE

Application for Enrolment

CONFIDENTIAL

Student Name:			
Calendar Year of Expected Entry:			
Year Level in which the student is to be enrolled		7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> Unsure <input type="checkbox"/>	
		Is the Student repeating this year? Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Has the student even been excluded from another school? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Date Enrolled	Date Left	Previous Location/School	Principal's Signature
Date Re-enrolled	Date Left	Previous Location/School	Principal's Signature
Date Re-enrolled	Date Left	Previous Location/School	Principal's Signature
Date Re-enrolled	Date Left	Previous Location/School	Principal's Signature
Date Re-enrolled	Date Left	Previous Location/School	Principal's Signature

OFFICE USE ONLY			
CHECKLIST FOR OFFICE		STUDENT INDUCTION PROCESS	
Date of meeting:		Possible Learning Support:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Commencement Date:		Special Circumstances:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Class allocated to:		Birth Certificate:	Yes <input type="checkbox"/> No <input type="checkbox"/>
CES Student Code:		Medicare Immunisation Records:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Student Photo taken:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Academic Reports:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Psychologist Report	Yes <input type="checkbox"/> No <input type="checkbox"/>	NAPLAN results	Yes <input type="checkbox"/> No <input type="checkbox"/>
Parent at Interview	Yes <input type="checkbox"/> No <input type="checkbox"/>	Vision Screener:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Disability Verification (through EAP)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hearing Screener:	Yes <input type="checkbox"/> No <input type="checkbox"/>
		MAI	Yes <input type="checkbox"/> No <input type="checkbox"/>
		PM Reading Level	Yes <input type="checkbox"/> No <input type="checkbox"/>
		NCCD Level	

Deputy Principal	Curriculum Coordinator	Inclusion Support Coordinator
Signed:	Signed:	Signed:

SECTION 1**STUDENT INFORMATION**

Surname or Family Name
Given Name/s
Other names known by or preferred name

Student's Indigenous Status	Is the student of Aboriginal or Torres Strait Islander origin
No <input type="checkbox"/>	Yes, Torres Strait Islander <input type="checkbox"/>
Yes, Aboriginal <input type="checkbox"/>	Yes, both Aboriginal & Torres Strait Islander <input type="checkbox"/>
If YES – Student's Indigenous Information	
Area:	Tiwi <input type="checkbox"/> Other <input type="checkbox"/> _____
Skin Group:	Pandanas <input type="checkbox"/> Mullet <input type="checkbox"/> Sun <input type="checkbox"/> Rock <input type="checkbox"/> Other <input type="checkbox"/>
Dance	_____

Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Other <input type="checkbox"/>
Date of Birth (dd/mm/yyyy)			
Student Mobile Number			
Residential Address:			

Religion			
Sacraments	Baptism <input type="checkbox"/> Reconciliation <input type="checkbox"/> Eucharist <input type="checkbox"/> Confirmation <input type="checkbox"/>		

Is the student in the care of Territory Families? Yes No

SECTION 2**STUDENT BACKGROUND INFORMATION**

Student's first language (What language/s is used most by the student when learning to talk?) Tiwi <input type="checkbox"/> Other Additional Language/s spoken:	Does the student speak a language other than English at home? English only <input type="checkbox"/> Other/s _____ (please specify)
In which country was the student born? Australia <input type="checkbox"/> Other _____ (please specify)	Is the student currently enrolled at another school? Yes <input type="checkbox"/> No <input type="checkbox"/>

SECTION 3**DETAILS OF STUDENT'S PREVIOUS FORMAL EDUCATION****Details of student's previous school/s**

School Name	Date of Leaving	Year, Grade or Level attained	State or Territory	Country (if not Australia)
	/ /			
	/ /			
	/ /			
	/ /			

SECTION 4**SIBLING INFORMATION****List all children in the family from ELDEST TO YOUNGEST – including the enrolling student**

Brother's / Sister's given names	Surname	DOB	School	Current Year Level at School	Lives with

SECTION 5 A**STUDENT MEDICAL INFORMATION****Medicare Card details**

Medicare Card Number	
Expiry Date (dd/mm/yy)	
What number is the student on the Medicare Card?	

Is there a history of family illness?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If YES – please state what illness	

Indicate if the student has been affected by or suffers from any of the following?

*Medical Plan completed and signed by medical practitioner to be provided.	Yes	No
Asthma *	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/convulsions *	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes *	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylaxis *	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health issues: depression, anxiety, self-harm	<input type="checkbox"/>	<input type="checkbox"/>
Illicit drug use eg gunja or synthetic cannabis	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (give details)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition (Eg Rheumatic Heart Disease)	<input type="checkbox"/>	<input type="checkbox"/>
A.D.D. / A.D.H.D.	<input type="checkbox"/>	<input type="checkbox"/>
ASD	<input type="checkbox"/>	<input type="checkbox"/>
Kidney condition	<input type="checkbox"/>	<input type="checkbox"/>
Migraines or headaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>
Eye problems	<input type="checkbox"/>	<input type="checkbox"/>
Is there anything else the school needs to know about the student?	<input type="checkbox"/>	<input type="checkbox"/>
Any learning difficulties, disabilities, sicknesses	<input type="checkbox"/>	<input type="checkbox"/>
Is the student taking any medication regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

Provide further details for any of the above:

Are there any sports or other physical activities in which the student should NOT participate?

No Yes

If Yes – please specify:

SERVICE	Yes	No	NAME OF CENTRE / PRACTITIONER	DATE OF VISIT OR REPORT	IS YOUR CHILD ATTENDING NOW?
Speech Pathologist	<input type="checkbox"/>	<input type="checkbox"/>			
Occupational Therapist	<input type="checkbox"/>	<input type="checkbox"/>			
Physiotherapist	<input type="checkbox"/>	<input type="checkbox"/>			
Psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>			
Psychologist	<input type="checkbox"/>	<input type="checkbox"/>			
Audiology Clinic (hearing)	<input type="checkbox"/>	<input type="checkbox"/>			
If YES, provide details					
Optometrist (eyes)	<input type="checkbox"/>	<input type="checkbox"/>			
If YES, provide details					
Paediatrician	<input type="checkbox"/>	<input type="checkbox"/>			
Inclusion Support	<input type="checkbox"/>	<input type="checkbox"/>			
If YES, provide details.					
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>			
If YES, provide details					

SECTION 6

PARENT / GUARDIAN / CARER INFORMATION

Details of the person responsible for the Day to Day care of the student.

Parent / Guardian / Carer No 1 Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Mr <input type="checkbox"/>	Parent / Guardian / Carer No 2 Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Mr <input type="checkbox"/>
Given Name/s	Given Name/s
Surname	Surname
Preferred name	Preferred name
Marital Status	Marital Status
Gender	Gender
Religion	Religion
Relationship to Student Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> _____ <input type="checkbox"/>	Relationship to Student Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> _____ <input type="checkbox"/>
Residential Address (Forestry, Jubilee Park, Milikapiti, Darwin etc)	Residential Address (Forestry, Jubilee Park, Milikapiti, Darwin etc)
LOT number	LOT number
Occupation	Occupation
Employer	Employer
If NOT, do you receive Centrelink Payments Yes <input type="checkbox"/> No <input type="checkbox"/>	If NOT, do you receive Centrelink Payments Yes <input type="checkbox"/> No <input type="checkbox"/>
Highest level of education Year 9 <input type="checkbox"/> Year 10 <input type="checkbox"/> Year 11 <input type="checkbox"/> Year 12 <input type="checkbox"/> TAFE <input type="checkbox"/> University <input type="checkbox"/>	Highest level of education Year 9 <input type="checkbox"/> Year 10 <input type="checkbox"/> Year 11 <input type="checkbox"/> Year 12 <input type="checkbox"/> TAFE <input type="checkbox"/> University <input type="checkbox"/>
Mobile Number	Mobile Number
Email Address	Email Address
Language/s Spoken	Language/s Spoken
Past student of XCC Yes <input type="checkbox"/> No <input type="checkbox"/>	Past student of XCC Yes <input type="checkbox"/> No <input type="checkbox"/>
Aboriginal / Torres Strait Islander Culture Yes <input type="checkbox"/> No <input type="checkbox"/>	Aboriginal / Torres Strait Islander Culture Yes <input type="checkbox"/> No <input type="checkbox"/>
Skin Group Dance	Skin Group Dance
Nationality	Nationality
Country of Birth	Country of Birth
Do we contact you in case of an EMERGENCY?	Do we contact you in case of an EMERGENCY?
If NOT, please supply details for an EMERGENCY contact? Name Mobile Address	If NOT, please supply details for an EMERGENCY contact? Name Mobile Address

I understand that by enrolling at Xavier Catholic College Wurrumiyanga, I am agreeing to abide by the three school rules:

1. Stay Safe
2. Respect Everyone
3. Learn Everyday

I understand that Xavier Catholic College Wurrumiyanga has a **Zero Tolerance Towards Fighting Policy**. I understand that this means if I am involved in a fight or any serious threatening behaviour at the school, I could receive an automatic one week suspension.

I understand Xavier Catholic College Wurrumiyanga provides all students enrolled at the school with Information Communication and Technology (ICT) facilities for educational use. Students may use these facilities for class work, research and the preparation of assignments. The resources provided include computers and laptops and access to the student drive. Care must be taken to ensure the resources are protected from harm and that no users are exposed to materials considered offensive or illegal. Failure to follow the rules could result in a ban of technology use.

I understand the use of Mobile phones are only to be used at recess and lunch times or before and after school. Mobile phones are not to be used in the classroom. If the mobile phone is used during class, there will be only one warning before the mobile phone is confiscated for the day. The use of the mobile phone during break times must not be used to video nor be used to communicate inappropriately with others.

Child's Name:

Student's signature:

Dated:

- I give permission for my child to be given first-aid treatment by a member of staff or emergency medical workers, if required.
- I give permission for my child to take part in immunisation programs according to the NT schedule for Aboriginal immunisations. These immunisations will be given by staff from the clinic.
- I give permission for my child to take part in vision (eyes), hearing (ears) and dental (teeth), and health checks by the clinic. If you do not want to give permission for Xavier staff to take your child to the clinic, please let the school know.
- I give permission for the school to share health information about my child with the clinic and associated organisations working with the clinic.
- At Xavier Catholic College Wurrumiyanga we have employed a School Psychologist. I consent to my child accessing the school psychologist service for initial support at any time. I understand that should the School Psychologist determine that ongoing sessions would be of benefit to my child that an individual referral will be made and my consent sought prior to this occurring.
- I give permission for my child to attend local excursions on Bathurst or Melville Island organised by Xavier Catholic College Wurrumiyanga that occur during the day and within school hours.
- I give permission for the school to take and use photos or videos of my child and display images and school work in school magazines, newsletters, displays, journals, on the XCC Facebook page, the XCC Youtube channel and Xavier Catholic College Wurrumiyanga Website to promote Xavier Catholic College Wurrumiyanga in a positive and sensitive manner.
- I give permission for my child to participate in the School Nutrition Program where the school provides breakfast, morning tea and lunch. I understand that this will deduct \$43.48 out of my Centrelink payment every fortnight.

Child's Name: _____

Parent / Guardian / Carer signature: _____

Dated: _____



Xavier Catholic College

PMB 139 Winnellie NT 0822

Telephone: 08 8978 397

Email: admin.xcec@nt.catholic.edu.au

SECTION 9 RELEASE OF STUDENT CONFIDENTIAL DOCUMENTS

I give permission for copies of my child's school reports to be transferred from

_____ to Xavier Catholic College and the release

(Previous school name)

of information about my child's learning and medical needs.

- Most recent school report
 - NAPLAN results – most recent
 - PM Benchmark Reading level
 - MAI Growth Point (Maths)
 - Spelling results
 - Speech Reports
 - Hearing Reports
 - Vision Reports
 - Occupational Therapy Reports
 - Reading Assessments
 - Paediatrician Reports
 - Behavioural Management Plans
 - Education Adjustment Plans or Personal Learning Plans
 - Psychological Assessments
 - Recent PAT Test results.
 - Any other information that is thought will help the students' schooling needs.
-
- I consent to the school contacting the Wurrumiyanga Clinic regarding general medical information on my child and sharing documents required in the best interest of the student.

Child's Name: _____

Parent / Guardian / Carer signature: _____

Child's Date of Birth: _____

Dated: _____



SECTION 10

XAVIER CATHOLIC COLLEGE PRIVACY POLICY

We as Parents/Carers acknowledge that the school will collect personal information about us and our child which might be required by the school to function and conduct its activities.

We consent to the school collecting, using and disclosing such personal information including the sensitive information set out in this enrolment form in accordance with the school's Privacy Policy and:

Generally, in such manner and in such circumstances as the school considers appropriate for the purposes of the school's functions and activities and for the education, health care, welfare or development of our child.

Child's Name: _____

Parent / Guardian / Carer signature: _____

Child's Date of Birth: _____

Dated: _____