Ιερά Αρχιεπισκοπή Αυστραλίας

The Greek Orthodox Parish & Community Of Kogarah & District "Resurrection Of Christ" Limited

Panagia Myrtidiotissa, Resurrection of Christ, Agia Elesa

Ελληνική Ορθόδοξη Ενορία και Κοινότητα Kogarah και Περιχώρων

Τρισυπόστατος Ναός Παναγίας Μυρτιδιωτίσσης, Αναστάσεως του Χριστού, Αγίας Ελέσης

16-20 Belgrave St, Kogarah NSW 2217

P.O. Box 260 Kogarah NSW 2217

Church Office - (02) 9587 5945. Greek School Email - schools@kogarahgreekorthodox.org.au

Greek School Mobile – 0432 291 226

GREEK SCHOOL ENROLMENT FORM 2019

Student Attending: (Please Tick)

Monday ☐	**Tuesday** ☐	**Wednesday** ☐	**Thursday** ☐	**Friday** ☐	**Saturday** ☐
Sans Souci☐	Ramsgate☐	Bald Face ☐ Carlton South ☐	Brighton ☐ Mortdale ☐ Hurstville ☐	Carlton☐	Kogarah ☐

Student Details: (Please Attach Copy Of Birth Certificate-New Students Only)

Surname:	
Given Name:	
Full Name in Greek:	
Sex **(Please Tick)** Male ☐ Female ☐	Date of Birth ___/____/____
Day School Name and Suburb:	
Year Level in Day School:	
Year Level in Greek School:	
Student Lives With Primary Family: **(Please Tick)** Always ☐ Mostly ☐ Balanced ☐ Custody Order: **(Please Tick)** Yes ☐ No ☐ **If Yes, please attach court order documents.**	

Emergency Contact Details: (Please List THREE Contacts)

	Name	Relationship	Telephone Number
1			
2			
3			

Medical History:

Does the student have any medical conditions?

Yes ☐

No ☐

If Yes, please specify:

Does the student suffer from Allergies or Asthma?

If Yes, an Action Plan must be attached.

Yes ☐

No ☐

List Symptoms:

If the student displays any of the above symptoms please:- **(Please Tick)**

Administer Medication ☐

Inform Emergeny Contact ☐

Call Ambulance ☐

Other Medical Action ☐

Please Specify:

Does the student take medication(s)? **(Please Tick)**

Yes ☐

No ☐

If yes, name of medication(s):

Does the student suffer from any of the following impairments? **(Please Tick)**

Hearing: Yes ☐ No ☐

Speech: Yes ☐ No ☐

Vision: Yes ☐ No ☐

Mobility: Yes ☐ No ☐

If Yes to any, please provide details:

Sudent Medicare Number:

Ambulance Cover: **(Please Tick)**

Yes ☐

No ☐

If yes, please provide <u>Name</u> of Fund and <u>Cover Number</u>:

Primary Family Details

Parent/Guardian A Details: (Fill In * All Details Requested)

Surname: *		
Given Name(s): *		
Relationship to student: *		
Address: *		
Telephone Numbers: Home: *	Work: *	Mobile: *
Email Address: *		

Parent/Guardian B Details: (Fill In * All Details Requested)

Surname: *		
Given Name(s): *		
Relationship to student: *		
Address: *		
Telephone Number: Home: *	Work: *	Mobile: *
Email Address: *		

From time to time we may take pictures and/or conduct video recordings during school projects. We would like your permission to use the images resulting from the photography/video filming, and any reproductions or adaptations of the images for fundraising, publicity or other purposes to help achieve the school's aims. This might include (but is not limited to) the right to use them in their printed and online publicity, social media, press releases and funding applications.

☐ YES I grant you permission to use photos and video recordings of my child.
☐ NO Please do NOT take or use any photos/ video recordings of my child.

_____ _____

Parent/Guardian Signature Date