



NEW ENROLMENT APPLICATION

Learning Support Supplementary Information

Student Name		Surname	
DOB		Year Level	

Please complete the table below to advise of any medical/learning diagnosis associated with your child. The information provided will assist with collating the necessary data relating to individual students and will allow the Learning Support Team, Educators to verify the evidence being used to support a student's inclusion. Additionally, the below information will serve in equipping all staff to support the student whilst in our care.

1. Indicate the specific condition/diagnosis by marking the box/s
2. Attach copies of the relevant Medical Document confirming diagnosis (eg: Psychiatric Report/OT/Speech/Paediatrician/Educational Psychologist etc.)
3. Attach copies of Individual Education Plan/s from previous school (IEP/ILP)

Diagnosis	Please attach copies of the medical document supporting a diagnosis	Staff Use Only	
		Confirming Report	Document Plan
COGNITIVE			
ADHD	<input type="checkbox"/> Specialist Medical Report *	<input type="checkbox"/>	<input type="checkbox"/>
Autism Spectrum Disorder (ASD)	<input type="checkbox"/> Paediatrician or Psychiatrist <input type="checkbox"/> Speech Pathologist <input type="checkbox"/> Psychologist } All 3	<input type="checkbox"/>	<input type="checkbox"/>
Central Auditory Processing Disorder (CAPD)	<input type="checkbox"/> Specialist Medical Report*	<input type="checkbox"/>	<input type="checkbox"/>
Global Development Delay	<input type="checkbox"/> Specialist Medical Report*	<input type="checkbox"/>	<input type="checkbox"/>
Dev. Coordination Disorder (DCD) Dyspraxia	<input type="checkbox"/> Specialist Medical Report * <input type="checkbox"/> Occupational Therapist	<input type="checkbox"/>	<input type="checkbox"/>
Dysgraphia	<input type="checkbox"/> Specialist Medical Report * <input type="checkbox"/> Occupational Therapist	<input type="checkbox"/>	<input type="checkbox"/>
Dyslexia (Specific Learning Disorder Reading)	<input type="checkbox"/> Specialist Psychologist Report*	<input type="checkbox"/>	<input type="checkbox"/>
Dyscalculia (Specific Learning Disorder Maths)	<input type="checkbox"/> Specialist Psychologist Report *	<input type="checkbox"/>	<input type="checkbox"/>
Dysgraphia (Specific Learning Disorder Writing)	<input type="checkbox"/> Specialist Psychologist Report *	<input type="checkbox"/>	<input type="checkbox"/>
Speech/Language Disorder	<input type="checkbox"/> Speech Pathology Report <input type="checkbox"/> Psychologist Report *	<input type="checkbox"/>	<input type="checkbox"/>
PHYSICAL			
Arthritis	<input type="checkbox"/> Specialist Medical Report*	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Problems/Crohn's	<input type="checkbox"/> Specialist Medical Report *	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/> Specialist Medical Report *	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/> Specialist Medical Report *	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (Type 2)	<input type="checkbox"/> Specialist Medical Report *	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/> Specialist Medical Report *	<input type="checkbox"/>	<input type="checkbox"/>
Fine Motor Disabilities	<input type="checkbox"/> Specialist Medical Report *	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury – Severe	<input type="checkbox"/> Paediatrician Report <input type="checkbox"/> Psychologist Report *	<input type="checkbox"/>	<input type="checkbox"/>

NEW ENROLMENT APPLICATION (Cont.)
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Diagnosis	Please attach copies of the medical document supporting a diagnosis	Staff Use Only	
		Confirming Report	Document Plan
PHYSICAL (Cont.)			
<i>Irlen Syndrome (Scotopic Sensitivity)</i>	<input type="checkbox"/> Specialist Medical Report *	<input type="checkbox"/>	<input type="checkbox"/>
<i>Muscular Dystrophy</i>	<input type="checkbox"/> Specialist Medical Report *	<input type="checkbox"/>	<input type="checkbox"/>
<i>Neurological Disability</i>	<input type="checkbox"/> Specialist Medical Report*	<input type="checkbox"/>	<input type="checkbox"/>
<i>Rheumatism</i>	<input type="checkbox"/> Specialist Medical Report *	<input type="checkbox"/>	<input type="checkbox"/>
<i>Scoliosis</i>	<input type="checkbox"/> Specialist Medical Report * <input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
SENSORY			
<i>Colour Blindness</i>	<input type="checkbox"/> Specialist Medical Report *	<input type="checkbox"/>	<input type="checkbox"/>
<i>Deaf or Hearing Impaired</i>	<input type="checkbox"/> Audiologist Report <input type="checkbox"/> Nose & Throat Therapist *	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<i>Vision Impaired</i>	<input type="checkbox"/> Ophthalmologist or Orthoptist Report <input type="checkbox"/> Neurologist or Paediatrician Report *	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
SOCIAL/EMOTIONAL			
<i>Anorexia Nervosa/Bulimia</i>	<input type="checkbox"/> Specialist Medical Report *	<input type="checkbox"/>	<input type="checkbox"/>
<i>Depression (Severe)</i>	<input type="checkbox"/> Specialist Medical Report *	<input type="checkbox"/>	<input type="checkbox"/>
<i>Panic Attacks</i>	<input type="checkbox"/> Specialist Medical Report *	<input type="checkbox"/>	<input type="checkbox"/>
<i>Psychological/Clinical Anxiety</i>	<input type="checkbox"/> Specialist Medical Report *	<input type="checkbox"/>	<input type="checkbox"/>
<i>Severe Mental Disorder</i>	<input type="checkbox"/> Clinical Psychologist/Psychiatrist *	<input type="checkbox"/>	<input type="checkbox"/>
<i>Tremor</i>	<input type="checkbox"/> Specialist Medical Report *	<input type="checkbox"/>	<input type="checkbox"/>

* Reports Confirming Diagnosis

MENTAL HEALTH ALERT			
Risk of Self Harm	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Details:			
Risk of Harm to Others	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Details:			

Other Diagnosis (not covered above)	Explanation	Staff Use Only	
		Confirming Report	Document Plan
+ Medical Reports Confirming Diagnosis + Previous School Documented Plan/s			
1.		<input type="checkbox"/>	<input type="checkbox"/>
2.		<input type="checkbox"/>	<input type="checkbox"/>
3.		<input type="checkbox"/>	<input type="checkbox"/>

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MEDICATIONS			
Medication	Reason	Dosage	Time Administered

Is your child currently funded through:

- | | | |
|--------------------------------------|------------------------------|-----------------------------|
| Disability Services Commission | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Centreline | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| National Disability Insurance Scheme | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Insurance Compensation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Therapy Focus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Details:

1. I understand that completing this form does not guarantee a secure place at Dale Christian College
2. The above is a true and correct representation of the information to hand, at the time of signing
3. I have included all medical/learning diagnosis with the most recent, supportive documentation confirming the diagnosis
4. Should my child secure a firm place at Dale Christian College, I will advise the College and supply updated medical and/or learning diagnosis documentation and information in good timing

<p>Parent/Guardian Name</p> <div style="border: 1px solid black; height: 25px; width: 100%;"></div> <p>Parent/Guardian Signature</p> <div style="border: 1px solid black; height: 25px; width: 100%;"></div> <p>Date</p> <div style="border: 1px solid black; height: 25px; width: 100%;"></div>	<p>Parent/Guardian Name</p> <div style="border: 1px solid black; height: 25px; width: 100%;"></div> <p>Parent/Guardian Signature</p> <div style="border: 1px solid black; height: 25px; width: 100%;"></div> <p>Date</p> <div style="border: 1px solid black; height: 25px; width: 100%;"></div>
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