☐ Creche / ☐ 3-6 Years REGISTRATION FORM

Buller Ski & Snowboard School

Please complete ONE REGISTRATION FORM per child each season (please print)

Child s Name: ____________________ AGE: ________ D.O.B.: ___/___/___

Parent/Guardian: ____________________

Home Address: ____________________

Phone: ____________________ Mobile Phone: ____________________

Language spoken at home: ____________________

Does the child live with the mother? ☐ Yes ☐ No Does the child live with the father? ☐ Yes ☐ No

Are there any COURT ORDERS relating to the powers and responsibilities of the parents in relation to the child or access to the child? ☐ Yes / ☐ No

2nd Home address: ____________________

Holiday Address: ____________________

Room/Apt. number: ____________________ Phone: ____________________

EMERGENCY CONTACTS:

OTHER PERSONS WHO CAN ACCEPT RESPONSIBILITY

In the event that the child has an illness/accident,
And the **parent/guardian CANNOT be contacted.**

Name: ____________________

Address: ____________________

Phone: ____________________

Mobile: ____________________

Relationship to child: ____________________

OTHER PERSONS AUTHORISED TO COLLECT CHILD

In the event that the parent/guardian is UNABLE TO:

Name: ____________________

Phone: ____________________

Relationship to child: ____________________

MEDICAL AND HEALTH INFORMATION

Name of Doctor/Medical Service: ____________________

Address: ____________________ Phone: ____________________

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING: TICK

BEHAVIOURAL ISSUES OR SPECIAL NEEDS? ☐ Yes ☐ No

If yes, please give details: ____________________

ALLERGY/SENSITIVITY/DIETARY RESTRICTIONS? ☐ Yes ☐ No

If yes, please give details: ____________________

MEDICAL CONDITIONS? Eg Asthma, epilepsy, diabetes...... ☐ Yes ☐ No

If yes, please give details: ____________________

IS THE CHILD ON ANY MEDICATIONS AT PRESENT? ☐ Yes ☐ No

If yes, please complete medication book and ask staff for assistance.

If yes, please give details: ____________________

NAME OF PERSONS WHO MAY AUTHORISE THE ADMINISTRATION OF MEDICATION AND MEDICAL TREATMENT:

NAME: ____________________ NAME: ____________________

ADDRESS: ____________________ ADDRESS: ____________________

PHONE: ____________________ PHONE: ____________________

HAS THE CHILD BEEN IMMUNIZED? ☐ Yes ☐ No

If yes, please attach a copy of the child's Immunization records...OR complete the table below

Immunization	2mths	4mths	6mths	12mths	18mths	4-5yrs
Diptheria/Tetanus/Pertusis						
OPV (Oral Polio Vaccine – Sabine)						
MMR (Measles, Mumps, Rubella)						
HIB (Pedvax HIB/HIBTITER)						

Hepatitis B (if given, please provide dates) ____________________ Other: ____________________

I have carefully read both sides of this agreement and sign it with full knowledge of its significance:
I am at least 18 years of age.

____________________ ____________________ ____________________

Signed on this Date Print Name Signature of Parent / Guardian

PRIVACY STATEMENT – See website: www.mtbuller.com.au for privacy statement