Springfield Central State High School

Believe Belong Become

Student Change of Details Form

STUDENT DETAILS

Please list all students at Springfield Central State High School these changes are applicable to:

Family Name:	Given Name:	Preferred Name:	Year Level:
Family Name:	Given Name:	Preferred Name:	Year Level:
Family Name:	Given Name:	Preferred Name:	Year Level:

PARENT / CARER DETAILS - **(Please complete relevant details only)**

	Parent / Carer 1		Parent / Carer 2	
Family Name				
Given Name				
Relationship to Student				
Emergency Contact	☐ Yes	☐ No	☐ Yes	☐ No
Resides with Student	☐ Yes	☐ No	☐ Yes	☐ No
Receives Correspondence	☐ Yes	☐ No	☐ Yes	☐ No
Receives SMS	☐ Yes	☐ No	☐ Yes	☐ No
Occupation / Workplace				
Preferred Correspondence Method	☐ Email	☐ Post	☐ Email	☐ Post
Mobile Number				
Work Number				
Home Number				
Email Address				
Address				
Suburb / Postcode				
Country of Birth / Main Language				
Residency Status				
Occupation Group				
School Education Level				
Non-School Education Level				
Blue Card Details (if applicable)				

CURRENT MEDICAL CONDITIONS: (including allergies)

Name of Student		**Name of Student**	
Medical condition		**Medical condition**	
Symptoms		**Symptoms**	
Management		**Management**	
Medication		**Medication**	

If there is an Individual Management Plan available for your student if necessary for anaphylaxis, diabetes, asthma, epilepsy or other conditions?

☐ Yes ☐ No *(If yes, please provide a copy to the school)*

If student is taking medication, a letter is required from Doctor/Parent with dosage details of medication. Medication MUST be supplied in original packet/bottle with label from pharmacy and all required school documentation will need to be completed.

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EMERGENCY CONTACTS ☐ **Replace Existing** ☐ **Add to Existing**

Emergency Contact	**Emergency Contact**
Priority Number: ______ Name: ______________________________ Home Phone: ______________________________ Mobile: ______________________________ Relationship to Student: ______________________	Priority Number: ______ Name: ______________________________ Home Phone: ______________________________ Mobile: ______________________________ Relationship to Student: ______________________
Emergency Contact	**Emergency Contact**
Priority Number: ______ Name: ______________________________ Home Phone: ______________________________ Mobile: ______________________________ Relationship to Student: ______________________	Priority Number: ______ Name: ______________________________ Home Phone: ______________________________ Mobile: ______________________________ Relationship to Student: ______________________
Emergency Contact	**Emergency Contact**
Priority Number: ______ Name: ______________________________ Home Phone: ______________________________ Mobile: ______________________________ Relationship to Student: ______________________	Priority Number: ______ Name: ______________________________ Home Phone: ______________________________ Mobile: ______________________________ Relationship to Student: ______________________

CONSENT

By signing this form, you are confirming that all information is true and correct.

Parent / Carer Name: ____

Parent / Carer Signature: ____

Effective Date: ____________

FINANCE AGREEMENT

Parent / Carer responsible for student/s finances while enrolled at Springfield Central State High School.

Parent / Carer Name: ____

Parent / Carer Signature: ____

Effective Date: ____________

Please email to admin@springfieldcentralshs.eq.edu.au

ADMINISTRATION OFFICE USE ONLY	FINANCE OFFICE USE ONLY
Date Received:	Date Received:
Date Entered into OneSchool:	Date Entered into OneSchool:
Administration Officer Signature:	Finance Officer Signature: