



Avon City Training Services

STAR/Gateway

Student Application To Enrol Form

P O Box 11008
Sockburn
Christchurch 8443

Phone 03 348 4129
Fax 03 348 4414
Email training@acford.co.nz

INSTRUCTIONS

- Complete all sections of the form.
- Print your answers clearly in **pen**, and tick any boxes that apply for multi-choice questions.

COURSE TITLE:	COURSE NUMBER:
----------------------	-----------------------

Course Start Date:	Course End Date:
---------------------------	-------------------------

PERSONAL DETAILS

1	<i>Given First Name(s):</i>	
	<i>Legal Surname:</i>	
	Preferred first name:	
	Address: (Include Street, Suburb, Town/City)	
	Contact/Mobile Number:	

2	Current High School/College:	
----------	-------------------------------------	--

3	Date of birth:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	4	Gender:	<i>Male</i> <input type="checkbox"/>	<i>Female</i> <input type="checkbox"/>	<i>Diverse</i> <input type="checkbox"/>
----------	-----------------------	---	----------	----------------	--------------------------------------	--	---

5	NSN (National Student number)	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>
----------	--------------------------------------	--

6	Ethnicity	<i>NZ Maori</i> <input type="checkbox"/>	<i>NZ European</i> <input type="checkbox"/>	<i>Pasifika</i> <input type="checkbox"/>
		<i>Other</i> <input type="checkbox"/> <i>Please specify...</i>		
	Iwi Affiliations (if known)	<i>Iwi:</i>		

MEDICAL CONDITIONS & DISABILITIES	The following information is confidential. Disclosure of information will not influence your acceptance onto the programme.			
	Do you live with any of the following? Yes <input type="checkbox"/> No <input type="checkbox"/>			
	If yes, please indicate your condition/disability by ticking one or more of the boxes below:			
	Hearing impairment	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
	Visual impairment	<input type="checkbox"/>	Mental Health difficulties	<input type="checkbox"/>
	Mobility impairment	<input type="checkbox"/>	Chronic Medical conditions - <i>Please specify</i> _____	
	Specific learning difficulty	<input type="checkbox"/>	Other - <i>Please specify</i> _____	
	Allergies/allergic Reactions	<input type="checkbox"/>	Reader / Writer Required? YES / NO	
	*For any long-term medical conditions, please attach a Treatment Plan for use whilst on the course.			
	Contact in case of an emergency			

Name:	Relationship:	Phone:
-------	---------------	--------

DECLARATION

Privacy – Avon City Training Services collects and stores information from this form to comply with the requirements of the Education Act 1989, and its obligations under other enactments and in accordance with the Privacy Act 1993.

NB: The Privacy Act came into force on 1 July 1993 with the stated aim of protecting the privacy of Natural persons. It requires the Academy to collect, hold, handle, use and disclose personal information in accordance with the twelve information privacy principles in the Act. <http://www.privacy.org.nz/people/peotop.html>

_____	____/____/____
<i>Signature of Applicant</i>	<i>Date</i>

School Coordinator has checked all information is correct. _____
Signature of School Coordinator