Student Full Name: ……..……

Student Details

Details	
Student First Name:	
Surname:	
Gender:	
Date of Birth:	
Class Grade Year (currently studying)	
School:	

Study session detail (optional)	Day and timing selected (optional)

Parent/Guardian 1

Parent/Guardian 2

SKOLENHOZ STUDY CENTRE,
Shop 4, 10 Old Glenfield Road, Casula, NSW 2170
and
6 Ambon Road, Holsworthy, NSW 2173

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Student Full Name: …….

Student Health Details (please circle your answer)

Health details	**Choose**
Does your child present with any additional support needs or have a diagnosed disability?	Yes No
Does your child or anyone in your family have any infectious disease ?	Yes No
Is your child vaccinated for Covid-19 ? If yes , how many doses have been administered ?	Yes No
Is every eligible person in your family vaccinated for Covid-19 ? If yes , how many doses have been administered ? (Please provide details):	
Does your child have allergies? (if yes please list):	Yes No
Does your child have anaphylactic reactions ? (if yes please list)	Yes No
Does your child have Asthma?	Yes No
Does your child have diabetes?	Yes No
Will your child require staff to administer regular medication? (If yes, please discuss with Skolenhoz staff)	Yes No
Does your child have any special dietary precautions? (If yes please provide details)	Yes No

If you have selected yes to any of the above, please provide a related Management Plan from your Doctor and arrange a meeting.

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