ASHTONFIELD PUBLIC SCHOOL

PO Box 2540 Greenhills NSW 2323

Phone 4934 3584 Fax 4934 3510 Email ashtonfiel-p.school@det.nsw.edu.au

CHANGES TO STUDENT AND FAMILY INFORMATION

Student/s Name: _____ **Class/es:** _____

Address: _____

Home Phone: _____

Mother's Contact Details: _____ **Work** _____ **Mobile**

Father's Contact Details: _____ **Work** _____ **Mobile**

Email: _____ **(Mother)** ☐

_____ **(Father)** ☐

Please tick preferred email for school correspondence.

Emergency Contacts: (Refers to additional contacts, not parents/carers, i.e friends, relatives that the school can contact if unable to contact parents).

Name: _____ Name: _____

Home Phone: _____ Home Phone: _____

Mobile: _____ Mobile: _____

Relationship to Student: _____ Relationship to Student: _____

Doctor's Name or Medical Centre: _____

Doctor's Address: _____

Doctor's Phone: _____ Medicare Number: _____

Medical Conditions/Allergies etc. (additional information to be completed – see office)

_____

_____

Permission to seek information from doctor/medical centre named above about how to manage any allergy or medical condition experienced by student: ☐ Yes ☐ No

Parent Signature: _____ Date: _____

Together We Succeed