

ROTORUA BOYS' HIGH SCHOOL



APPLICATION FOR ADMISSION TO

TAI MITCHELL BOARDING HOSTEL

PROPOSED STUDENT: _____
CHRISTIAN NAMES (in full) SURNAME

PROPOSED COMMENCEMENT DATE: _____

DOB: _____ Current Form Level: _____

Current School: _____

Please enclose together with this duly completed application form:

- A non-refundable Administration fee of \$200.00
- Rotorua Boys' High School Enrolment Form (if not already attending Rotorua Boys' High School)
- Reference and/or most recent Report from present school.
- Birth Certificate
- Medical Certificate
- Signed Declaration

Address application to:
Rotorua Boys' High School
Hostel Application
Pukuatua Street
Rotorua

OFFICE USE ONLY

Administration Fee Paid:.....	<input type="checkbox"/>	Date Acknowledgement Sent:.....	<input type="checkbox"/>
Interview Date:	<input type="checkbox"/>	Interviewed by:.....	<input type="checkbox"/>
		Hostel Commencement Date:.....	<input type="checkbox"/>
Student Loaded on KAMAR.....	<input type="checkbox"/>	Hostel Fees Loaded on KAMAR:.....	<input type="checkbox"/>
Copied to:.....	Hostel Master <input type="checkbox"/>	Hostel Manager <input type="checkbox"/>	Doctor <input type="checkbox"/> Dean <input type="checkbox"/>

STUDENT DETAILS & DECLARATION

Student's Name _____
Christian Names _____ Surname _____

Date of Birth _____ Age as at 1st January next _____ yrs _____ mths

Ethnic Background _____ (Tribe) _____

Present School _____ Present Class _____

Form _____ Year _____

To be completed by **both** parents/guardians

FATHER

MOTHER

Full Name _____ Full Name _____

Private Address _____ Private Address _____

Phone _____ Phone _____

Phone (Bus) _____ Phone (Bus) _____

Occupation _____ Occupation _____

DECLARATION

1. I _____ am the Natural/Adoptive Parent/Legal Guardian of the applicant.

2. The applicant and I have read the Hostel Handbook and have sighted and agree to expectations regarding:

(i) Hostel Rules and Conventions

(ii) Hostel Fees Policy

(iii) Hostel Property Damage Policy

(iv) Boarding Education Trust

(v) Personal Computer Policy

(vi) Property Damage Policy

(vii) Hostel Early Withdrawal Policy

(viii) Damage/Loss of Personal Effects Policy

(ix) Hostel Refund Policy

(x) Search

(xi) Substance Abuse Procedures

(xii) Using our son's name and photo on the school website and other school publications

3. Please print the name and address of the person(s) or organisation to whom the accounts should be sent and who is directly responsible for the payments of the accounts.

Name

Address

Signature of Parent/Guardian _____ Date: _____

Signature of Applicant _____ Date: _____

MEDICAL DETAILS

Student's Name _____
(Christian Names) (Surname)

Date of Birth _____

HAS HE UNDERGONE ANY OPERATION? If so, give date and particulars

HAS HE HAD A SERIOUS ILLNESS OR ACCIDENT? If so, give date and particulars

HAS HE HAD:

Measles	yes <input type="checkbox"/>	no <input type="checkbox"/>	Recurring Tonsillitis	yes <input type="checkbox"/>	no <input type="checkbox"/>	Meningitis	yes <input type="checkbox"/>	no <input type="checkbox"/>
Mumps	yes <input type="checkbox"/>	no <input type="checkbox"/>	Ear Infection	yes <input type="checkbox"/>	no <input type="checkbox"/>	Hepatitis 'A'	yes <input type="checkbox"/>	no <input type="checkbox"/>
Chickenpox	yes <input type="checkbox"/>	no <input type="checkbox"/>	Glandular Fever	yes <input type="checkbox"/>	no <input type="checkbox"/>	Hepatitis 'B'	yes <input type="checkbox"/>	no <input type="checkbox"/>
Malaria	yes <input type="checkbox"/>	no <input type="checkbox"/>	Rheumatic Fever	yes <input type="checkbox"/>	no <input type="checkbox"/>	Pneumonia	yes <input type="checkbox"/>	no <input type="checkbox"/>

DOES HE HAVE:

Epilepsy	yes <input type="checkbox"/>	no <input type="checkbox"/>	Sight problems	yes <input type="checkbox"/>	no <input type="checkbox"/>	Diabetes	yes <input type="checkbox"/>	no <input type="checkbox"/>
Hayfever	yes <input type="checkbox"/>	no <input type="checkbox"/>	Hearing Loss	yes <input type="checkbox"/>	no <input type="checkbox"/>	Asthma	yes <input type="checkbox"/>	no <input type="checkbox"/>

Bed Wetting Problems yes no

Long term medication _____

Other illnesses _____

Allergies - **please specify**

To medication _____

To foods _____

Others _____

PARTICULARS OF INOCULATIONS AND VACCINATIONS

Triple Vac - Date _____ Tetanus - Date _____ Hepatitis 'B' - Date _____

ANY FURTHER HEALTH PROBLEMS THAT WE SHOULD BE AWARE OF?

NEXT OF KIN (To be notified in case of emergency)

1.	Name _____	Relationship _____
	Address _____	Phone (Home) _____
	_____	Phone (Work) _____
2.	Name _____	Relationship _____
	Address _____	Phone (Home) _____
	_____	Phone (Work) _____
3.	Name _____	Relationship _____
	Address _____	Phone (Home) _____
	_____	Phone (Work) _____

Signature of Parent _____ Date _____ Phone _____

MEDICAL REPORT

To be completed & signed by Family Doctor

Medical Report on behalf of _____ as to state of general health from family Doctor.

Does he have or has he ever suffered from:	Yes	No	Details of Medication Required
Asthma			
Epilepsy			
Diabetes			
Rheumatic Fever			
Other: (Please Specify)			
Does he have any Allergies			
Medication			
Food			
Stings			
Other (Please Specify)			
Does the student suffer from any other medical condition, disability or special circumstance?			

Doctors Full Name: _____

Doctors Signature: _____

Date: _____