

 **CASUAL ENROLMENT FORM**

**ENROLMENT FORM**

**Fields marked with \* are compulsory**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Legal Name\*** | (Title) | **Family Name**  | **First Name(s)** | **Middle Name(s)** |
|  |  |  |  |
| **Other Name(s)** Eg: Maiden Name/Preferred Name)Please tick the name you prefer to be known as |  | **NHI****(office Use only)** |  | **I.D:** | **Photo I.D. sighted ****Address Verified** **** |
|  |  |
| **Birth Details\*** |  **Day/Month/Year of Birth\*** | **Place of Birth\*** | **Country of Birth\*** |
|  |  |  |
| **Gender\*** |  |  |  **Gender diverse (please state)** |  **Student ID No:**  |
| **Male** |  **Female** | **Gender Assigned at Birth: F/M****Preferred Gender you Identify as:** |
| **During Academic****Year. Residential****Address\*** |  |  |  |
| **House (or RAPID) Number and Street Name** | **Suburb/Rural Location** | **Town / City and Postcode** |
| **Postal Address**(if different from above) |  |  |  |
| **House Number and Street Name or PO Box Number** | **Suburb/Rural Delivery** | **Town / City and Postcode** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Contact Details** |  |  | I agree to receiving Txt messages Yes ****No****  |
|  |
|  **Mobile Phone** |  **Home Phone** | Email Address |
| **Emergency Contact/NOK** |  |  |  |
| Name | Relationship | Mobile (or other) Phone |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Community Services Card**  |  |  |  |  |
| Yes | No | Day / Month / Year of Expiry | Card Number |
| **High User Health Card** |  |  |  |  |
| Yes | No | Day / Month / Year of Expiry | Card Number |
| **NZAID Student**  | ******Yes** | ******No** | **Permanent Resident** | Yes **** No **** | **Allergies:** to medication please specify. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Smoking Status:** | Smoker **** | Never Smoked **** | Ex-Smoker ****No. years since quit   |
| **Cervical Screening** **Status: Normal ****Date:**  | **Previous Abnormal:****Date:** | **HPV Vaccine:**  Yes **** No ******Date:**  |

|  |
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| **Ethnicity Details** |
|  Which ethnic group(s) do you belong to? (Tick multiple boxes if needed, including Iwi.) New Zealand European Maori Samoan Cook Island Maori Tongan Niuean Chinese Indian Other (such as Dutch, Japanese, Tokelauan). Please state: **Iwi****Consent to Share Health Information with other Health Providers involved in my care:** Yes ****No **** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signatory Details** |  |  |  |
| Signature | Day / Month / Year | Self Signing |
|  |  |  |  |