



DIVERSE LEARNER ENROLMENT INFORMATION

STUDENT DETAILS	
Student Name:	Year level:
Name of previous school:	
Interests	Student's main interests:
School Support	Has the student accessed the following supports? <input type="checkbox"/> Special Education Program <input type="checkbox"/> Learning Support <input type="checkbox"/> Psychologist <input type="checkbox"/> Guidance Officer <input type="checkbox"/> Chaplain <input type="checkbox"/> School Nurse <input type="checkbox"/> Other; Please specify
Attendance	Attendance patterns:
Behaviour	Triggers: Set Routines: Intervention Details:
DIVERSE LEARNER DETAILS – HAS THE STUDENT BEEN PROVIDED WITH ADDITIONAL SUPPORTS PREVIOUSLY?	
Language/ Background	Was the student born in Australia? <input type="checkbox"/> Yes <input type="checkbox"/> No, please provide details What is the main language spoken at home? <input type="checkbox"/> English <input type="checkbox"/> Other, please provide details

	<p>Does your child identify as Aboriginal/Torres Strait Islander? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, please confirm if they spend time in community</p>
<p>Disability Information</p>	<p><input type="checkbox"/> Sensory (e.g., Hearing, Vision) <i>Details</i></p> <p><input type="checkbox"/> Cognitive (e.g., Learning Difficulties e.g. Dyslexia, Dysgraphia, Intellectual Disability, ADHD) <i>Details</i></p> <p><input type="checkbox"/> Social-emotional (e.g., anxiety, depression, ASD, ADHD) <i>Details</i></p> <p><input type="checkbox"/> Physical (e.g., spina bifida, cerebral palsy) <i>Details</i></p>
<p>Curriculum</p>	<p>Has the student had any specific adjustments/tailored supports: e.g., Teacher Aide, focussed/intensive classes, small group classes etc.</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes, please provide details</p> <hr/> <p>Individual Curriculum Plan (ICP):</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes, please specify the <u>subject and year level</u>:</p>
<p>Medical Diagnosis</p> <p><i>Please provide supporting documentation.</i></p>	<p>Has the student been diagnosed with any medical conditions? (e.g., ASD, ADHD, Dyslexia, Intellectual Disability)</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, please provide details</p> <p>Document is attached: <input type="checkbox"/> No <input type="checkbox"/> Yes</p>
<p>Medication</p>	<p>Does your child take any medications that may need to be administered during school hours?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, please specify:</p>

	<p>Does your child take any medications outside of school hours?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, please specify:</p>
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EXTERNAL SUPPORT PROVIDERS

Specialist Support	<p>In the past two years, has your student seen any of the following specialists?</p> <table border="0"> <tr> <td><input type="checkbox"/> Paediatrician</td> <td><input type="checkbox"/> Speech Pathologist</td> </tr> <tr> <td><input type="checkbox"/> Counsellor</td> <td><input type="checkbox"/> Occupational Therapist</td> </tr> <tr> <td><input type="checkbox"/> Child Youth & Mental Health</td> <td><input type="checkbox"/> Child & Family Health</td> </tr> <tr> <td><input type="checkbox"/> Psychiatrist</td> <td><input type="checkbox"/> Psychologist</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Other Health Care Providers, please specify:</td> </tr> </table> <p>Is the student a current patient and/or in process of seeing the identified specialists above?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<input type="checkbox"/> Paediatrician	<input type="checkbox"/> Speech Pathologist	<input type="checkbox"/> Counsellor	<input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Child Youth & Mental Health	<input type="checkbox"/> Child & Family Health	<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> Psychologist	<input type="checkbox"/> Other Health Care Providers, please specify:	
<input type="checkbox"/> Paediatrician	<input type="checkbox"/> Speech Pathologist										
<input type="checkbox"/> Counsellor	<input type="checkbox"/> Occupational Therapist										
<input type="checkbox"/> Child Youth & Mental Health	<input type="checkbox"/> Child & Family Health										
<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> Psychologist										
<input type="checkbox"/> Other Health Care Providers, please specify:											

National Disability Insurance Scheme (NDIS)	<p>Are you receiving NDIS support/assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you need NDIS referral assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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OFFICE USE ONLY	<p><input type="checkbox"/> Refer student to:</p> <p><input type="checkbox"/> Save the form in:</p> <p><input type="checkbox"/> Interstate (<i>request information</i>):</p> <p><input type="checkbox"/> Diagnosis Follow-up</p> <p><input type="checkbox"/> QLD (<i>check OS once activated, contact relevant school</i>):</p>
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