Cheltenham Community Centre
SHORT COURSE ENROLMENT FORM 2010

Personal Details:	Family Name:		First Name:
			Date of Birth:
Address:			Post Code:
Email Address:			Please tick if would you like CCC info updates ☐
Phone: (H)	(W)		(M)

Emergency Contact Information:	
Name:	Phone:
Relationship:	Mobile:

Medical condition: Do you have a medical condition or permanent disability that we should know about or that may affect your participation in class? Y / N *(if yes, please circle disability type)*

Disability: ☐ Vision ☐ Hearing ☐ Physical ☐ Intellectual ☐ Chronic Illness ☐ Learning ☐ Mental Illness ☐ Acquired Brain Impairment

Medical condition: ☐ Allergies ☐ Diabetes ☐ Epilepsy ☐ Heart

Other (*please indicate*):

How did you find out about our program?:
☐ Flyer in mailbox ☐ Ad in local paper ☐ Word of mouth ☐ Website ☐ Street Signage
☐ Other (please state)___________

PRIVACY STATEMENT

Cheltenham Community Centre (CCC) offers a range of education and community programs.

When you enrol with us, we ask for details about yourself which will be used as our point of contact. This information is **only** used for funding and planning purposes.

You are also required to provide us with an emergency contact. Please ensure that this person is aware that their contact details have been given to us and that you have their consent to provide this information.

If you have any concerns about providing the information requested, please speak to our reception staff who will be able to assist you. Please be assured that any information provided to us is kept confidential and any concerns you may raise about the way we handle your information will also be kept confidential.

If you would like access to the records we hold about you or you would like to correct or update any information, please speak to reception staff who would be pleased to discuss this with you.

PHOTOGRAPH & VIDEO AUTHORITY

I give permission to CCC to use my photograph &/or video footage for the use of CCC activities… eg. AGM presentation or advertising

☐ **Yes** ☐ **No**

MEDICAL AUTHORITY

I authorise you in the event of injury or accident to obtain medical assistance for me as required.

☐ **Yes** ☐ **No**

I have read the above information and understand the purposes for the collection of my personal information and information I have given about others.

Name:.. Date:......................................

Signature:..

CCC COURSE INFORMATION

Fees:					CONCESSION: Yes ☐ No ☐
Course Name:				**Course Code**	**Total Fees**
					$
					$
					$
					$
OFFICE USE ONLY:					
Student ID:	Entered by:			Date:	