



Registration Form

PLEASE PRINT CLEARLY

School Contact Details

School	_____		
Street Address	_____		
Postal Address	_____		
Contact Teacher	_____	Position	_____
Telephone	_____	Fax	_____
Email	_____		

Availability

Preferred Term (please circle)	1 (Feb – Apr)	2 (Apr – Jul)	3 (Jul – Sept)	4 (Oct – Dec)
Preferred Day/s (please circle)	Monday	Tuesday	Wednesday	Thursday Friday
Anticipated number of students (write number against each yr)	Year 8:	Year 9:	Year 10:	
	Year 11:	Year 12:	No. of classes:	

Equipment Requirements (Please circle availability)

White Board	Yes	No
TV & DVD Player	Yes	No
Carpeted Floor	Yes	No

School Hours

Start Time _____	Finish Time _____
Recess _____	Lunch _____
Class Duration _____	

■ We prefer at least two course bookings per school ■ Courses need to be conducted consecutively on the same day ■
Please contact the course coordinator to discuss your booking requirements

Thank you and please fax back to St John Ambulance on 9334 1224