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 3:	Year 4:	Year 5:		
	Year 6:	Year 7:	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