



MABEL PARK STATE HIGH SCHOOL HEALTH TRAINING HUB

Expression of Interest for the School Based Health Services Program

First Name			
Last Name			
Date of Birth		Gender	M <input type="checkbox"/> F <input type="checkbox"/>
School		Year Level	
Home Email			
School Email			
Student Mobile			
Address			
Parent/Guardian Name			
Parent Contact	Mobile:	Email:	
Do you identify as: (please tick)	<input type="checkbox"/> From a non-English speaking background <input type="checkbox"/> A student with a disability or impairment	<input type="checkbox"/> Aboriginal or Torres Strait Islander <input type="checkbox"/> I do not wish to disclose <input type="checkbox"/> None	

Explain in 25-50 words why you would like to be a part of the Health Services Program.

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Please return this **completed EOI form** to your school VET coordinator.

Student signature

I agree to my student participating in the Health Services Program

Parent / Guardian signature

For further information contact Mrs Judy Fewtrell, Head of Senior Schooling
Ph: 3489 2333
Email: admin@mabelparkshs.eq.edu.au