



# Canterbury Girls High School Illness/Misadventure Appeal

To be completed by a student who is unable to attend/submit an assessment task on due date or who believes their performance in the task has been adversely affected due to illness or misadventure. **This form must be submitted to the Deputy Principal the first day back at school immediately after the assessment task. If the Deputy Principal is absent this must be submitted to the Head Teacher.**

Name: ..... Year: .....

Subject/course: .....

Head Teacher: ..... Teacher: .....

Assessment Title: .....

Date of Notification: ..... Due Date: .....

Date appeal submitted: .....

Either (tick option):  Task missed/not submitted  Task sat for

Seeking special consideration because of:  Illness  Misadventure

Details of appeal:  
.....  
.....  
.....

(Attach all necessary medical and other certificates and letter from parent/caregiver)

Student Name: ..... Signature: .....

Date: .....

Parent/Caregiver Name: ..... Signature: .....

Date: .....

### Head Teacher Recommendation:

Head Teacher Name: ..... Signature: .....

*HT to present appeal to Deputy Principal*

### School Response:

Deputy Principal Name: ..... Signature: .....  
Principal Name: ..... Signature: .....

*DP consults P; DP gives copy to HT; HT informs teacher and student of school response; DP enters in Sentral: DP gives original to SAM for student file and a copy to be mailed to Parent/caregiver*

**STUDENT MEDICAL/MISADVENTURE CERTIFICATE**

*Purpose of this certificate*

This form is used by students to apply for illness/misadventure in exams or other assessable work in their studies at Canterbury Girls High School. Approval of applications is granted to students who are legitimately disadvantaged in their assessment due to factors beyond their control. To enable the validity of applications to be evaluated, this form should be completed by a doctor, dentist, or other appropriate authority (e.g. police officer, solicitor)

**STUDENT NAME** \_\_\_\_\_

*I agree to Canterbury Girls High School requesting verification of the information provided on this certificate, if required.*

Student Signature \_\_\_\_\_ Contact No: \_\_\_\_\_

Parent /Guardian Signature \_\_\_\_\_ Contact No: \_\_\_\_\_

**PRACTITIONER DETAILS (to be completed by the doctor, dentist or other relevant authority)**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

Stamp of practitioner or organisation

I, \_\_\_\_\_, certify that I have seen  
\_\_\_\_\_ on \_\_\_/\_\_\_/\_\_\_\_\_

***In my opinion, the student has a medical condition or is experiencing matters which did/will affect their studies as follows:***

	Tick as applicable	Provide applicable dates
Unable to attend classes		From ___/___/___ to ___/___/___
Unable to undertake private study		From ___/___/___ to ___/___/___
Unable to sit exams		From ___/___/___ to ___/___/___

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of practitioner \_\_\_\_\_ Date \_\_\_\_\_



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