CONDOBOLIN HIGH SCHOOL
MISADVENTURE/NON COMPLETION FORM

This form is to be completed if:

1. You failed to attend or submit an assessment task on time;
2. An absence/inability to complete is known in advance;
3. You attended an assessment task and felt that your performance had been affected by an illness or misadventure that occurred immediately before or during the assessment task.

For 1, you must complete the form immediately (within two school days) of returning to school.
For 2, this form must be completed in advance of the 'due date.'
For 3, you must tell a supervising teacher of the problem during the task and complete this form immediately (returned within 2 school days).

In all cases once the form is completed, it must be given to the Assessment Coordinator
– Mrs Bev Small

Student Name: ________________________________ Year: _________________
Subject: _______________________________   Due Date of Task: ____/____/_____

Time of Task: Period _____ (If in class assessment)

☐ Inability to complete/failure to attend or submit an assessment task on time
☐ Performance affected by illness/misadventure

Please tick the relevant square above.

Supporting Statement by Student
(To be completed by the student with reasons why)

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Signed: ________________________________ Date: ________________

Parent/Guardian Signature: ______________________________ Date: ________________
(for students under 18 years of age)
Supporting Statement by Health Professional or Other Relevant Person (to be completed as proof for reason above)

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Statement by Class Teacher/Head Teacher

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Date Received: __________________
Teacher:_____________________ Head Teacher: _____________ Deputy Principal: _____________ Date: ______

Assessment Panel - Decision

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Date Received: ________________
Signed (Assessment Coordinator/Deputy Principal): _________________ Date: ______________

Copies to:

| Head Teacher – Faculty                  | Date: __________________________ |
| Class Teacher                           | Date: __________________________ |
| Student (via Head Teacher)              | Date: __________________________ |
| Original to Student File                | Date: __________________________ |
| Letter to Parent                        | Date: __________________________ |

STUDENTS DO HAVE THE RIGHT OF APPEAL TO THE PRINCIPAL IF THEY FEEL THE DECISION WAS UNJUST