

Kindaburra Children's Centre

1 Jersey Lane Off 463 Bunnerong Road, MATRAVILLE NSW 2036 Tel: 93117011

Enrolment Form

Child's Given Name/s: Family Name:
Other Names the Child is known by:
Other Names the Child has been known by:
Gender: M / F DOB: / / Address:
Place of Birth:
Home Phone:
Bill Fees To: Mother / Father / Other Receive Statement of Account via email: Y / N
Legal Guardian: Religion:
Indigenous Status: Special Needs: Y / N Disability: Y / N
Cultural Background: Primary Language:

Information required to claim CCB:

CCB Hours Nominated: Y / N If Yes - Number of Hours to be used in this Centre:
Child CRN: Claimant CRN:
Claimant: Mother / Father / Other DOB: / / Name:
Claimant Email:
Receive Usage Statements via Email: Y / N

Mother's Given Name: Family Name:
Other Names the Mother is known by:
Other Names the Mother has been known by:
Address:
Home Phone Mobile Phone:
Email Address:

Work Details: Employer: Suburb:
Work Phone: Hours: Occupation:

Father's Given Name: Family Name:
Other Names the Father is known by:
Other Names the Father has been known by:
Address:
Home Phone Mobile Phone:
Email Address:

Work Details: Employer: Suburb:
Work Phone: Hours: Occupation:

Medical Details:

Does your Child take regular medication or have any disabilities, food sensitivities or allergies we should know about? Y / N

If Yes - Details:

Is there any other information you wish us to know about your child?

Has your Child had any Measles German Measles Ear Infection Hepatitis
of the following? Mumps Chicken Pox Throat Infection Other

Medicare No: Private Health Particulars:

Please supply a copy of your Child's ACIR Immunisation History Statement, ACIR Conscientious Objection Form, or ACIR Medical Contraindication Form.

Emergency Details:

Doctor's Name: Phone: Contact Doctor: Y / N

Address:

Dentist's Name: Phone: Contact Dentist: Y / N

Religious Requirements in case of Accident:

Nominate at least two people to act on your behalf in the following circumstances:

Pick Up from care; Pick Up in an emergency; Authorisation of medication; Authorisation of excursions

Name: Relationship to child:

Home Phone: Mobile Phone: Work Phone:

Home Address:

Work Address:

Daily Pick Up: Y / N Emergency Pick Up: Y / N Authorise Medication: Y / N Authorise Excursion: Y / N

Name: Relationship to child:

Home Phone: Mobile Phone: Work Phone:

Home Address:

Work Address:

Daily Pick Up: Y / N Emergency Pick Up: Y / N Authorise Medication: Y / N Authorise Excursion: Y / N

Name: Relationship to child:

Home Phone: Mobile Phone: Work Phone:

Home Address:

Work Address:

Daily Pick Up: Y / N Emergency Pick Up: Y / N Authorise Medication: Y / N Authorise Excursion: Y / N

Name: Relationship to child:

Home Phone: Mobile Phone: Work Phone:

Home Address:

Work Address:

Daily Pick Up: Y / N Emergency Pick Up: Y / N Authorise Medication: Y / N Authorise Excursion: Y / N

Name: Relationship to child:

Home Phone: Mobile Phone: Work Phone:

Home Address:

Work Address:

Daily Pick Up: Y / N Emergency Pick Up: Y / N Authorise Medication: Y / N Authorise Excursion: Y / N

Please add more Authorised Nominees overleaf if necessary. See Overleaf: Y / N

In the Event of an emergency, illness or accident concerning my child, I consent to the service seeking on my behalf urgent medical, dental, hospital and ambulance services for my child and I consent to the carrying out of appropriate medical, dental or hospital treatment in the event that such action appears to be necessary because my child has been injured, or is ill, at the premises. I accept any liability for medical, dental, hospital and ambulance that may be incurred.

I understand that the approved provider or nominated supervisor of the service will, as soon as practically possible, notify me or other persons so authorised by me of the accident or illness and the treatment or services arranged for my child.

Parent Signature: Date: / /

Family Circumstances:

Is there anyone who is prohibited from having contact with or collecting the child? Y / N

Details:

Care Required:

Days Req'd: Mon Tue Wed Thu Fri Hours of Care Req'd: Start Date Req'd: / /

Office Use Only:

Commencement Date: / / Days Attending: Mon Tue Wed Thu Fri

Child's Room or Group:Standard Attendance:

Birth Certificate Sighted: Y / Court Order Sighted: Y / N Immunisation Details Provided: Y /

Evidence of Priority: Y / Priority No:
