CONFIDENTIAL: RESTRICTED ACCESS

☑ Flexible / Casual ☐ Fixed / Routine

GREY WARD CHILDREN'S CENTRE
Enrolment Form: Part 1

253 Wright Street, Adelaide SA 5000, AU
Ph: (08) 8231 9195
Fax: (08) 8231 6285
lisa.hall277@schools.sa.edu.au

CHILD

Family Name: | Gender: F / M
First Name: | Other:
Known as: | Primary Language:
Date of birth: __ / __ / ____ | Birth Cert. cited: Yes / No | CRN:
Address:
Indigenous status: | Aboriginal: Yes / No | TS Islander: Yes / No

ELIGIBLE PARENT/GUARDIAN & BILLING DETAILS

Name:
Date of birth: __ / __ / ____ | CRN:
Relationship to child: | Contact Priority: ☐ | Primary Language:
Address: (h)
(w)
Phone: (h) (w) (m)
Email:

OTHER PARENT/GUARDIAN (if applicable)

Name:
Relationship to child: | Contact Priority: ☐ | Primary Language:
Address: (h)
(w)
Phone: (h) (w) (m)
Email:

EMERGENCY CONTACTS & COLLECTION AUTHORITIES

Name: | Contact Priority: ☐
Address: | Relationship to child:
Phone: (h) (w) (m)

Name: | Contact Priority: ☐
Address: | Relationship to child:
Phone: (h) (w) (m)

N.B. It is very important that you tell these people that you have nominated them. In nominating them you give them authority to act on the child's behalf if neither parent can be located, to pick up the child in an emergency and care for the child until s/he can be returned home.

COLLECTION AUTHORITIES ONLY

Name:
Address: | Relationship to child:
Phone: (h) (w) (m)

Name:
Address: | Relationship to child:
Phone: (h) (w) (m)

N.B. The people nominated here have been given approval only to collect the child and should NOT be contacted in case of an emergency.

BOOKINGS

	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Arrive:							
Depart:							

From: __ / __ / ____ for: ____ weeks / or until: __ / __ / ____ or Ongoing (tick) ☐

Enrolment Form: Part 2

Child's Name:

MEDICAL AND HEALTH INFORMATION

Has the child received the following immunisations? (please tick):

	Birth	2 months	4 months	6 months	12 months	18 months	4 years
Hepatitis B	☐	☐	☐	☐			
Diphtheria		☐	☐	☐		☐	☐
Tetanus		☐	☐	☐		☐	☐
Pertussis (Whooping Cough)		☐	☐	☐		☐	☐
Haemophilus b (Hib)		☐	☐	☐	☐		
Poliomyelitis		☐	☐	☐			☐
Meningococcal C					☐		
Measles					☐	☐	
Mumps					☐	☐	
Rubella					☐	☐	
Pneumococcal conjugate		☐	☐	☐			
Rotavirus		☐	☐	☐			
Varicella (Chickenpox)						☐	

Additional immunisations received for Aboriginal and Torres Strait Islander children in high risk areas? (please tick):

	6 mths - 5 yrs	12 - 18 months	12 - 24 months
Pneumococcal conjugate		☐	
Hepatitis A			☐
Influenza (Flu)	☐		

I accept full responsibility if my child is not immunised.

Parent / Guardian signature:

Has the child any disabilities? **Yes / No** **Effective date:** _ _ /_ _ /_ _ _ _

If yes, please record specifics:

Has the child any special needs? **Yes / No** **Effective date:** _ _ /_ _ /_ _ _ _

If yes, please record specifics:

Does the child usually require regular medication or special aids?

If yes, please specify (e.g. glasses, hearing aid etc.):

Has the child suffered any illness that may re-occur?

If yes, please specify (e.g. chronic ear infection):

Has the child had any kind of allergic reactions or food intolerances?

Foods: **Penicillin: Yes / No**

Others (Insects etc.):

Reaction:

Usual Medical attendant

Doctor's name: **Phone No.:**

Clinic name:

Address:

Usual Dental attendant

Dentist's name: **Phone No.:**

Clinic name:

Address:

Medical Benefits cover with:

Ambulance cover with:

Medicare number: **Health Care Card number:**

SLEEP NEEDS

approx. time(s) and duration:

Cot Bed Special Toy Dummy Bottle (please circle)

How do you settle your child when s/he becomes distressed?

DIET / FEEDING INFORMATION

Bottle Cup Feed self Spoon fed Trainer/Cup (please circle)

Likes:

Dislikes:

Amount:

Times:

Enrolment Form: Part 3

Child's Name:

UNIVERSAL ACCESS DATA COLLECTION

Does a parent/guardian/carer of this child have any of the following? (please circle)

Health Care Card:	**Yes / No**
Pensioner Concession Card:	**Yes / No**
Temporary Protection/Humanitarian Visa:	**Yes / No**
Bridging Visa for an Asylum Seeker:	**Yes / No**
Department of Veteran Affairs Gold Card:	**Yes / No**

If this child attends another funded Preschool program please complete the following:

Name of other Preschool/Kindergarten:

How many hours of attendance at other Preschool/Kindergarten:

PARENTING PLANS / ORDERS relating to this child

IS THERE ANYTHING MORE WE NEED TO KNOW?

(e.g. any personal, religious or cultural practices/prohibitions that you would like the service to know.)

CONSENTS

Please initial next to each item to which you consent.

I consent for my child to take part in supervised walking excursions within the local area as part of the Centre's program .

I consent for my child to be photographed and for their image and name to be published in circumstances the Director deems to be appropriate.

I consent for Centre staff to apply sunblock to my child if required.

I give consent for my child to be taken by a staff member to the local hospital or doctor's surgery in the event of a minor injury.

AGREEMENTS

I agree to pay the required fees for my child's booked childcare hours and accept the policies and rules of the Service.

I agree that the staff of the Service may administer simple first aid to my child if the need arises.

I understand that if at any time the staff of the Service consider that my child requires emergency medical/hospital/ambulance assistance, they will have the local medical/ hospital/ambulance attend my child. I acknowledge that I will be liable for any medical/ hospital/ambulance expenses incurred in the treatment of my child.

I certify that the information entered upon this form is true to the best of my knowledge and I undertake to inform the Service if any of these details change.

Parent / Guardian signature: **Date:** _ _ / _ _ / _ _ _ _

Interviewed / Accepted by: **Date:** _ _ / _ _ / _ _ _ _