# CHILD ENROLMENT FORM 2014

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|---|---|---|---|---|
| **CHILD'S FULL NAME** | | | | |
| Child's Address | | | | |
| **Name child is known by** | | | | |
| Commencement Date | | | | |
| **Customer Reference Number** | ☐☐☐ ☐☐☐ ☐☐☐ ☐ | | | |
| Gender | | | | |
| Child's Year Level/Grade in 2014 | | | | |
| Child's Date of Birth (DOB) | | | | |
| Child's Age at Enrolment | | Child's Weight (kgs) | | |
| Child's Country of Birth (COB) | | | | |
| Date child started or starts school | | | | |
| School attending in 2014 | | | | |
| Cultural Background | ☐ Aboriginal not TS Islander | ☐ TS Islander not Aboriginal | ☐ Aboriginal and TS Islander | ☐ Not Aboriginal or TS Islander |
| | Other: | | | |
| First (Primary) Language | | | | |
| Second Language | | | | |
| CHILD'S MEDICARE NUMBER | ☐☐☐☐ ☐☐☐☐☐ ☐ | | | |

## CARE ARRANGEMENTS

| | | |
|---|---|---|
| Name of the Primary Carer(s): | | |
| Are there any current written arrangements? Yes ☐ No ☐ Copy Provided Yes ☐ No ☐<br>*Relevant documentation may include parenting plans, parental responsibility plans, residence orders and contact order.*<br>TO ENABLE SERVICES TO COMPLY WITH COURT ORDERS A COPY MUST BE PROVIDED. | | |
| Is there anyone legally denied access to the child? Yes ☐ No ☐ Copy Provided Yes ☐ No ☐ | | |
| Full name of person legally denied access: | | |
| Address: | | Phone: |
| Work Name & Address: | | |

The following people are NOT authorised to collect my children: (please discuss with Coordinator of service)

1._____ Relationship to child: _____

2._____ Relationship to child: _____

## CULTURAL CONNECTIONS AND FAMILY TRADITIONS

| | |
|---|---|
| Does your family observe any particular religious or cultural practices that are significant to your child? | |
| Do you celebrate any cultural/religious traditions? How do you celebrate these traditions? | |
| What 'family' traditions do you celebrate together? (E.g. Dinner at grandmas every Sunday, camping on long weekends, etc.) | |
| Are there any specific songs/stories that you share with your child/ren? | |
| As a family do you have any favourite foods? Please provide details. | |

# MEDICAL INFORMATION

## CHILD'S FULL NAME

*Does your child regularly experience any of the following? Please ✓(tick) and provide details in space provided below. If yes, an individual action/medical care plan by an authorised medical practitioner may be required.*

| | | | |
|---|---|---|---|
| KNOWN ALLERGIES | YES | NO | What causes the allergy?<br>❒ Mild ❒ Severe ❒ Anaphylactic **(Epipen must be provided to the service at all times child is in care)**<br>Symptoms<br>Please provide details of any allergy management plans<br>Action plan attached: NO ❒ YES ❒ ***(A current year action plan from a medical practioner together with a current photo is required in order to proceed with this enrolment)*** |
| DIETARY RESTRICTIONS | YES | NO | Special dietary restrictions (provide details) |
| INTOLERANCES | YES | NO | What causes the intolerance?<br>❒ Mild ❒ Severe<br>Symptoms<br>Current Action plan (provide details) |
| ASTHMA | YES | NO | ❒ Mild ❒ Severe **(In order to proceed with this enrolment a current action plan is required)**<br>What symptoms does your child present with when experiencing asthma?<br>Asthma plan provided? NO ❒ YES ❒ [updated plan required when a change occurs] |
| IMMUNISATIOIN STATUS UP TO DATE | YES | NO | Hepatitis B NO ❒ YES ❒ / HIB NO ❒ YES ❒<br>Measles, mumps & rubella NO ❒ YES ❒ / Pneumococcal NO ❒ YES ❒<br>Whooping Cough NO ❒ YES ❒ / Rotavirus NO ❒ YES ❒<br>Diphtheria, tetanus & pertussis NO ❒ YES ❒ / Meningococcal C NO ❒ YES ❒<br>Polio NO ❒ YES ❒ / Varicella NO ❒ YES ❒<br>If your child's immunisation status is not up to date your eligibility to receive Child Care Benefit may be affected (if applicable for service type)<br>If NO, I have completed the "Agreement to Withdraw my Child" form NO ❒ YES ❒<br>If a child's vaccination record is incomplete the parent/carer will need to contact ACIR (Australian Childhood Immunisation Register) on 1800 653 809 to obtain current information. Please ensure the service is provided with updated records as your child is immunised. (Reg 162) |
| HIGH TEMPERATURES | YES | NO | Current Action plan (provide details) |
| SEIZURES | YES | NO | Known triggers<br>Current Action Plan (provide details) |
| **Office use only** | YES | NO | Is an individual medical care plan by an authorised medical practitioner required?<br>Yes ❒ No ❒ Date plan supplied to service _____/____/_____ expiry date _____/____/_____<br>Yes ❒ No ❒ Risk Minimisation Action Plan required (Reg 162)<br>Yes ❒ No ❒ Medical conditions policy provided to families<br>Yes ❒ No ❒ Health records for child sighted |

| | | | | |
|---|---|---|---|---|
| **Does your child take medication on a regular basis?** | YES | NO | Provide details | |
| **Do you have any queries/ concerns regarding your child's development** | YES | NO | Provide details | |
| **Is your child accessing any specialist support services?** | YES | NO | ❒ Speech therapy | |
| | | | ❒ Occupational therapy | |
| | | | ❒ Hearing | |
| | | | ❒ Vision | |
| | | | ❒ Mobility | |
| | | | ❒ Other | |
| **Does your child present with any additional needs or have a diagnosed disability?** | YES | NO | Provide details (*attach: Doctor's Certificate, written diagnosis or other relevant medical information)* | |
| **Any other relevant health management information e.g. Premature birth etc.** | YES | NO | Provide details | |

## MEDICAL CONTACT DETAILS

| | | | |
|---|---|---|---|
| **Child's Doctor** | | Phone Number | |
| Address | | | |
| **Child's Dentist** | | Phone Number | |
| Address | | | |
| **Paediatrician** | | Phone Number | |
| Address | | | |

## MEDICAL CONSENT STATEMENT (CONDITIONS OF ENROLMENT)

I/We understand, acknowledge and agree to the following:

- I/We authorise the nominated supervisor, educator or approved provider to provide any required first aid and to facilitate medical attention in the event of an emergency. I/We give permission for staff to obtain any medical, hospital and ambulance service in the case of an accident or emergency involving my/our child and accept responsibility for payment of all expenses associated with such treatment. I/We understand that every effort will be made to contact me/us in the event of any illness or accident (Reg. 161)
- On enrolling my/our child/ren I/we understand that the service is unable to care for children who are sick or who have a contagious illness. I/we further acknowledge that a medical clearance may be necessary before my/our child is able to return
- I/We understand that the service is unable to administer medication unless it is in its original container with the dispensing label attached listing the child as the prescribed person, and the dosage to be given. This includes prescribed (e.g. antibiotics) and non-prescribed medication (e.g. paracetamol)
- Prescribed medication will only be administered when it is accompanied by written instructions from the child's medical practitioner, is in the original container and the service medication form is completed
- I/We agree to complete the service medication form detailing the dose, time and date of last dose of any medication given to my/our child so as to reduce the risk of overdosing
- I/We give permission for first aid qualified staff to administer first aid and/or medication to my/our child as required

**Parent/Carer 1 Signature:** _____ Date: _____/_____/____

**Parent/Carer 2 Signature:** _____ Date: _____/_____/____

| **OFFICE USE ONLY** | | |
|---|---|---|
| Date Received: | Date Entered: | By Whom: |
| Orientation Completed: Yes ☐ No ☐ Date: | | Commencement Date: |