

**Enrolment Details**

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| **Enrolment** |
| Date of Enrolment: |  | Year Attending: |  |
| Session Requested: | Wednesday |  | Notes: |
| Thursday |  |
| Friday |  |
|  |
| **Child Details** |
| Full Name(s): |  |
| Address: |  |
| Date of Birth: |  | Birth Certificate Sighted: |  |
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| **(1) Parent(s) / Guardian(s)** |
| Full Name(s): |  |
| Address: |  |
| Phone (H): |  | Phone (M): |  |
| Phone (W): |  | Email: |  |
| Occupation: |  | Work Address: |  |
|  |
| **(2) Parent(s) / Guardian(s)** |
| Full Name(s): |  |
| Address: |  |
| Phone (H): |  | Phone (M): |  |
| Phone (W): |  | Email: |  |
| Occupation: |  | Work Address: |  |
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| **Authorised Nominee That May Bring The Child** |
| Full Name(s): |  |
| Address: |  |
| Phone (H): |  | Phone (M): |  |
| Phone (W): |  | Relationship to Child: |  |
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| **Authorised Nominee That May Collect The Child** |
| Full Name(s): |  |
| Address: |  |
| Phone (H): |  | Phone (M): |  |
| Phone (W): |  | Relationship to Child: |  |
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| **Person To Collect In An Emergency (Other Than Parent/Guardian) Or To Confirm Administration Of Medication** |
| Full Name(s): |  |
| Address: |  |
| Phone (H): |  | Phone (M): |  |
| Phone (W): |  | Relationship to Child: |  |
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| **Details Of Guardianship And Custody And Terms Of Any Specific Custody Or Access Provision** |
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| **Child’s Doctor** |
| Full Name(s): |  | Medicare No: |  |
| Address: |  |
| Phone (W): |  |  |
| Authorisation: | I hereby give my permission for Pre-Kindy to administer medication if nominated person cannot be contacted and to call medical advice in the case of an emergency and agree to pay any expenses incurred for medical treatment and transport. |
| Name: |  |
| Signed: |  | Date: |  |
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| **Information Relevant To Safety and Care of Child** |
| **Immunisations** |  |
| Fully Immunised | Yes | No | Notes: |  |
| Allergies |  |
| Anaphylactic | Yes | No | Notes: |  |
| ***Please Note:*** *Anaphylactic Shock, Asthma and Febrile Convulsions Require a Management Plan Attached* |
| Requires Regular Medical Attention or Medication | Yes | No | Notes: |  |
| Asthma or Recurrent Chest Infections | Yes | No | Notes: |  |
| Fits | Yes | No | Notes: |  |
| Premature Baby | Yes | No | Notes: |  |
| Skin Problems | Yes | No | Notes: |  |
| Eyesight Problems | Yes | No | Notes: |  |
| Other Chronic Health Problems | Yes | No | Notes: |  |
| Previous Illness or Operations: |  |
| Has your child been diagnosed with any of the following: |
| German Measles | Yes | No | Measles | Yes | No | Mumps | Yes | No |
| Whopping Cough | Yes | No | Chicken Pox | Yes | No | Other |
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| **Special Care Needs** |
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|  **Dietary, Cultural Or Religious Needs** |
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| **Other Information:** |
| Languages Spoken at Home: |  |
| Siblings Names: |  |
| Other Relevant Information: |  |
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| **Notes And Declaration:** |
| Outings | We will be conducting regular outings away from the approved premises. When an external outing is planned, you will need to attend with your child. We encourage members of the community to visit us, linking with our program. If you have any suggestions or can volunteer your time, please let us know. |
| Illness | A child cannot be accepted into our care with any illness which may, in any way, be transferred to others. |
| Media | Please inform us in writing if you **do not** wish for Atwell Pre-Kindy to publish photos of your child. |
| **Full Payment must be made prior to commencement of each term** |
| Signed By Parent or Guardian: |  | Date: |  |