

WATER STREET CHILD CARE AND KINDERGARTEN

(Approved Provider: Cairns & District Child Care Development Assoc Inc)

70 Water St, Cairns Qld 4870 Ph: (07) 4031 2983 Email: waterst70@bigpond.com



ENROLMENT FORM 2018

Today's Date: Commencement Date:

Child/ren

1. Family Name: Given Names:

DOB: Age on first day of attendance: Gender: **M/F** Hours of Attendance:

Residential

Address: CRN Number:

2. Family Name: Given Names:

DOB: Age on first day of attendance: Gender: **M/F** Hours of Attendance:

Residential

Address: CRN Number:

Child Care Subsidy: Are you already claiming CCS with another organisation? **YES / NO (circle)**

Please specify any talents, skills, knowledge or interests you may be able to share with us at the centre:

Parent/Guardian

CRN No:

Name:

D.O.B:

Address:

Home Phone:

Mobile:

Occupation:

Place of Employment:

Work Address:

Work Phone No:

Language spoken at home:

Authorised to collect child/ren **Yes/No**

Parent/Guardian

CRN No:

Name:

D.O.B:

Address:

Home Phone:

Mobile:

Occupation:

Place of Employment:

Work Address:

Work Phone No:

Language spoken at home:

Authorised to collect child/ren **Yes/No**

Is your child of Aboriginal or Torres Strait Islander origin? No **Yes Aboriginal** **Yes Torres Strait Is**

Do you have any special requirements eg. Cultural or religious requirements? **Yes / No**

If yes, please give details

Do both parents have custody/guardianship of child/ren? **Yes / No**

If **NO**, please provide a copy of the Custody/Guardianship papers for our file

AUTHORISED NOMINEE/EMERGENCY CONTACT (other than parent/guardian)

This person is authorised to carry out the following responsibilities for my child (please tick appropriate authorities)

In the event of an accident/incident you need to be able to come to the centre immediately. Emergency contact numbers are essential.

1.Name: Phone No: R/ship.....

Address:

Consent to medical treatment/authorise administration of medication
Authorise an educator to take the child outside the education and care service premises
Deliver or collect the child to/from the education and care service and authorisation for Qikkids Kiosk

2.Name: Phone No: R/ship.....

Address:

Consent to medical treatment/authorise administration of medication
Authorise an educator to take the child outside the education and care service premises
Deliver or collect the child to/from the education and care service and authorisation for Qikkids Kiosk

3.Name: Phone No: R/ship.....

Address:

Consent to medical treatment/authorise administration of medication
Authorise an educator to take the child outside the education and care service premises
Deliver or collect the child to/from the education and care service and authorisation for Qikkids Kiosk

4.Name: Phone No: R/ship.....

Address:

Consent to medical treatment/authorise administration of medication
Authorise an educator to take the child outside the education and care service premises
Deliver or collect the child to/from the education and care service and authorisation for Qikkids Kiosk

Medical Details:

Family Doctor: Address:
Phone No:
Child's Medicare Number: Number on card:

Does your child/ren have any allergies? **YES / NO**

If yes please complete an allergy details form
Plan sighted and filed **YES/NO (office use only)**

Has your child been diagnosed as at risk of anaphylactic reaction when exposed to an allergen? **YES / NO**

If yes please complete and allergy detail form and an Emergency medical action plan for your child
Plan sighted and filed **YES/NO (office use only)**

Does your child/ren suffer from Asthma? **YES / NO**

If yes please complete an Asthma management plan for your child.
Plan sighted and filed **YES/NO (office use only)**

Does your child/ren have any other illnesses? **YES / NO**

If yes please provide details:
.....
.....

Does your child/ren have any dietary restrictions? **YES / NO** **Personal** **Medical**

If yes please provide details:
.....
.....

Does your child/ren have any disability or other additional needs? **YES / NO**

If yes please provide details : (attach doctor's certificate, written diagnosis or other relevant medical information)
.....
.....

IMMUNISATION

I accept that it is my responsibility to ensure that the Water St Child Care and Kindergarten has an up to day record of my child/ren's immunisation. I understand that if my child is not immunised, he/she may be excluded from the centre for the recommended exclusion period, if another child contracts one of the illnesses for which there is an immunisation. I understand that this is for the protection of my own child/ren and for the protection of all concerned with the centre.

Is your child's immunisation up to date? **YES / NO**

Immunisation /Health record sighted - **YES/NO (office use only)**

Excursions:

Permission to take child/ren on local excursions:

I give permission for my child to participate in excursions from the centre, either by foot, car, bus or public transport, within the local community. I acknowledge that I will receive a notice and separate permission form on each occasion.

Parent's/guardian's signature _____ **Date** _____

Photographs: (Please circle where applicable)

I **do/do not** consent to photographs of my child/ren being taken for centre use only.

Head Lice:

If my child is believed to have head lice, I understand that I will be contacted immediately and asked to collect my child.

Medication:

All medication is to be given to a staff member and recorded in the medication register, all medication is stored in the medication storage box for safe keeping. Any medication administered is to be witnessed by two (2) staff members and is also to be signed by the parent. All prescribed medication must be in the original container with the child's name, date of issue and as per written instructions by the Doctor. NO un-prescribed medication will be administered. Any injury or treatment given while your child is at the centre is at the centre is recorded in our injury/incident form.

In the event of an emergency, I authorise a staff member with a First Aid Qualification to administer First Aid. I give consent for my child/ren to be transported by the Queensland Ambulance Service to the Cairns Hospital, and hereby agree that I will be responsible for any expenses associated therewith. I authorise the staff of the centre to seek emergency medical treatment/transport for my child should this be necessary.

Signed:(Parent/Guardian) **Date:**

Sunscreen/Insect Repellent:

I give permission for staff to reapply sunscreen/insect repellent supplied by the centre YES / NO

Signed:(Parent/Guardian) **Date:**

Kindergarten program only – Is your child enrolled in another Queensland Government Approved Program? If so where:.....

Do you authorise Water Street Child Care and Kindergarten to claim the program funding: **YES / NO**

I/Wehave read and understand the policies contained on this form and in the Water Street Child Care parent handbook.

I/We agree to abide by these policies.

Signed: (Parent/Guardian) **Date:**

Signed: (Parent/Guardian) **Date:**

If you would like to receive our monthly newsletter via email, please supply your email address.

Email Address:

