Kindaburra Children's Centre

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

Enrolment Form

Child's Given Name: ______________ Child's Family Name: ______________

Other Names the Child is known by: ______________

Other Names the Child has been known by: ______________

M / F: ____ DOB ______________ Address: ______________

Place of Birth: ______________ ______________

Home Phone: ______________ Bill Fees To: ______________

Legal Guardian: ______________ Religion: ______________

Primary Language: ______________ Cultural Background: ______________

Is there anyone who is prohibited from having contact with or collecting the child? ______________

____

Days Req'd Mon Tues Wed Thur Fri Hours of Care Req'd ______________ Start Date Req'd ______________

Information required to claim CCB:

CCB Eligible Hours ______________ Nominated Hours at this Centre ______________

Child's CRN: ☐☐☐ ☐☐☐ ☐☐☐☐

Parent/Guardian/Claimant Name: ______________

Parent/Guardian/Claimant Date of Birth: ______________ CRN: ☐☐☐ ☐☐☐ ☐☐☐☐

Inportant: Please make sure that the Parent/Guardian/Claimant Date of Birth, and the Parent/Guardian/Claimant CRN are for the person claiming CCB.

Mother's Given Name: ______________ Mother's 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 Mother: Employer: ______________ Suburb: ______________

Phone (W): ______________ Hours: ______________ Occupation: ______________

Father's Given Name: ______________ Father's 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 Father: Employer: ______________ Suburb: ______________

Phone (W): ______________ Hours: ______________ Occupation: ______________

Medical Details:

Does your Child take regular medication or have any disabilities, food sensitivities or allergies we should know about? Yes/No

If Yes give details: ______________________________

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

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

Medicare No: ____________________ Private Health Particulars: ____________________

Emergency Details:

Doctor's Name: ____________________ Phone No: ____________________ Contact Doctor Y/N _____

Address: ______________________________

Dentist's Name: ____________________ Phone No: ____________________ Contact Dentist Y/N _____

Religious Requirements in case of Accident: ______________________________

Using the boxes below, list at least 2 people authorised to collect the child and at least 2 people that we may call if we cannot find you in an emergency. These may be the same people for both situations.

Person's Name	Relationship to Child	Phone (H)	Phone (W)	Phone (Mobile)	Emerg. Release Y/N	Daily Pick Up Y/N
Home Address:						
Work Address:						
Home Address:						
Work Address:						
Home Address:						
Work Address:						
Home Address:						
Work Address:						

In the Event of an emergency, illness or accident concerning my child, and the teacher being unable to contact me or other persons so authorised by me, I consent to the Centre seeking on my behalf medical, dental, hospital & ambulance services for my child and I consent to the carrying out of appropiate 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.

Parent Signature ____________________ Date ____________________

Please supply evidence of immunisation - either your Blue Book or a letter from your doctor.

Office Use Only:

Commencement Date: ____________________ Total Allowable Absences at Commencement: ____________________

School Age Y/N: ______ School Start Date: ____________ Days Attending: ____________________

Child's Room or Group: ______________________ Standard Attendance: ____________________

Birth Certificate Sighted Y/N: _______ Court Order Sighted Y/N: ____________

Immunisation Details Available Y/N: _______

Evidence of Priority Y/N: _______ Priority No. ____________________