

---

## Enrolment Form

---

### **Parent/Guardian**

Title \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Middle Name \_\_\_\_\_ Gender \_\_\_\_\_

Parent/Guardian CRN \_\_\_\_\_ D.O.B. \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Fax \_\_\_\_\_ Mobile \_\_\_\_\_

Email \_\_\_\_\_

### **Address**

#### **Street Address**

Address1 \_\_\_\_\_

Address2 \_\_\_\_\_

Suburb \_\_\_\_\_

State \_\_\_\_\_ Post Code \_\_\_\_\_

#### **Postal Address**

Attention To \_\_\_\_\_

Same As Above

Address1 \_\_\_\_\_

Address2 \_\_\_\_\_

Suburb \_\_\_\_\_

State \_\_\_\_\_ Post Code \_\_\_\_\_

### **Medical**

Family Doctor \_\_\_\_\_ Doctor Phone \_\_\_\_\_

Medicare No. \_\_\_\_\_ Private Health Fund \_\_\_\_\_

Ambulance No. \_\_\_\_\_ Post Code \_\_\_\_\_

Notes \_\_\_\_\_

### **General**

Occupation \_\_\_\_\_ Country of Birth \_\_\_\_\_

Ethnicity \_\_\_\_\_ Religion \_\_\_\_\_

First Language \_\_\_\_\_ Second Language \_\_\_\_\_

Hobbies \_\_\_\_\_ Skills \_\_\_\_\_

---

**Partner**

Full Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Fax \_\_\_\_\_ Mobile \_\_\_\_\_

**Street Address**

Same As Above

Address1 \_\_\_\_\_

Address2 \_\_\_\_\_

Suburb \_\_\_\_\_

State \_\_\_\_\_ Post Code \_\_\_\_\_

Comments \_\_\_\_\_

**Family Contacts**

Full Name \_\_\_\_\_ Relation to Child \_\_\_\_\_

Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_

Fax \_\_\_\_\_ Mobile \_\_\_\_\_

Authorised in Emergency Yes / No Authorised for Pick Up Yes / No

Address1 \_\_\_\_\_

Address2 \_\_\_\_\_

Suburb \_\_\_\_\_ State \_\_\_\_\_ Post Code \_\_\_\_\_

Comments \_\_\_\_\_

Full Name \_\_\_\_\_ Relation to Child \_\_\_\_\_

Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_

Fax \_\_\_\_\_ Mobile \_\_\_\_\_

Authorised in Emergency Yes / No Authorised for Pick Up Yes / No

Address1 \_\_\_\_\_

Address2 \_\_\_\_\_

Suburb \_\_\_\_\_ State \_\_\_\_\_ Post Code \_\_\_\_\_

Comments \_\_\_\_\_

Full Name \_\_\_\_\_ Relation to Child \_\_\_\_\_

Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_

Fax \_\_\_\_\_ Mobile \_\_\_\_\_

Authorised in Emergency Yes / No Authorised for Pick Up Yes / No

Address1 \_\_\_\_\_

Address2 \_\_\_\_\_

Suburb \_\_\_\_\_ State \_\_\_\_\_ Post Code \_\_\_\_\_

Comments \_\_\_\_\_

## **Child**

First Name	Last Name	
Middle Name	Nickname	
Child CRN	D.O.B.	
Gender	School Student	Yes / No
Custody Particulars		
Comments		

## **Behaviours/Routines**

Toilet Trained	Yes / No	Details
Behavioural Difficulties		
General Routine		
Sleep Routine		
Fears		
Comforter		
Special Care Requirements	Yes / No	
Details		

## **Foods/Allergies**

Special Dietary Needs	
Food Likes	
Food Dislikes	
Allergy Alert	Yes / No
Known Allergies	
Medications	
Doctor Name	Doctor Phone

## **Medical/Immunisation**

Doctor Name	Doctor Phone
Medical Conditions	
Medications	
Immunisation Comments	

## **Immunisation Schedule**

Birth	Yes / No / Exempt
2 Months	Yes / No / Exempt
4 Months	Yes / No / Exempt
6 Months	Yes / No / Exempt
12 Month	Yes / No / Exempt
18 Months	Yes / No / Exempt
4 Years	Yes / No / Exempt

---

**General**

Country of Birth	
Ethnicity	Religion
First Language	Second Language
Hobbies	Skills

**Preferred Schedule**

Monday	Start:	End:	Total Hours:
Tuesday	Start:	End:	Total Hours:
Wednesday	Start:	End:	Total Hours:
Thursday	Start:	End:	Total Hours:
Friday	Start:	End:	Total Hours:
Saturday	Start:	End:	Total Hours:
Sunday	Start:	End:	Total Hours:

**Permissions & Agreements**

I give permission for centre staff to carry out or seek urgent medical, dental or hospital treatment or transportation by an ambulance service for my child.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I give permission for centre staff to apply 30 SPF sunscreen to my child's skin at regular intervals during the day.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I give permission for my child to be photographed whilst at the centre, for the purpose of developmental documentation. I understand that photographs will not be released to outside agencies, or used for promotional purpose without my written authority.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I give permission for the centre staff to administer one (1) dose of panadol to my child if required.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I understand that fees must be paid once invoiced within the stated due date and that my child's place at the centre may be terminated if fees are not up to date.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

---