

Alexander Kelly Drive Phone: (08) 8384 8177
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Noarlunga Community Childrens Centre
Enrolment Form: Part 1

CHILD

Family Name: Gender: F / M
 First Name: Other:
 Known as: Primary Language:
 Date of birth: / / CRN:
 Address: Postcode:
 Indigenous status: Aboriginal: Yes / No TS Islander: Yes / No

ENROLLING PARENT/GUARDIAN & BILLING DETAILS

Name:
 Date of birth: / / CRN:
 Relationship to child: Contact Priority: Primary Language:
 Address: (h) Postcode:
 (w)
 Phone: (h) (w) (m)
 Email:

PARENTS OCCUPATIONS (optional)

OTHER PARENT/GUARDIAN (if applicable)

Name:
 Relationship to child: Contact Priority: Primary Language:
 Address: (h)
 (w)
 Phone: (h) (w) (m)

EMERGENCY CONTACTS & COLLECTION AUTHORITIES

Name: Contact Priority:
 Address: Relationship to child:
 Phone: (h) (w) (m)

Name: Contact Priority:
 Address: Relationship to child:
 Phone: (h) (w) (m)

N.B. It is very important that you tell these people that you have nominated them. In nominating them you give them authority to act on the child's behalf if neither parent can be located, to pick up the child in an emergency and care for the child until s/he can be returned home.

ENROLMENT FEE \$10.00

AMOUNT PAID:

SIGN AND DATE:

IN CARE ELSEWHERE

I am claiming Childcare Benefit at other Approved Child Care Service/s (which includes LDC,OSHC,FDC,IHC,OCC) for this number of children:

BOOKINGS

	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Arrive:							
Depart:							

From: / / for: weeks / or until: / / or Ongoing (tick)

Enrolment Form: Part 2

Child's Name:

MEDICAL AND HEALTH INFORMATION

Has the child received the following immunisations? (please tick):

	Birth	2 months	4 months	6 months	12 months	18 months	4 years
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Diphtheria		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Tetanus		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Pertussis (Whooping Cough)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Haemophilus b (Hib)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Poliomyelitis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Meningococcal C					<input type="checkbox"/>		
Measles					<input type="checkbox"/>		<input type="checkbox"/>
Mumps					<input type="checkbox"/>		<input type="checkbox"/>
Rubella					<input type="checkbox"/>		<input type="checkbox"/>
Pneumococcal conjugate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Rotavirus		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Varicella (Chickenpox)						<input type="checkbox"/>	

Additional immunisations received for Aboriginal and Torres Strait Islander children in high risk areas? (please tick):

	12 - 24 months	18 - 24 months
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal polysaccharide		<input type="checkbox"/>

I accept full responsibility if my child is not immunised.
Parent / Guardian signature:

Has the child any disabilities? Yes / No Effective date:

If yes, please record specifics:

Has the child any special needs? Yes / No Effective date:

If yes, please record specifics:

Does the child usually require regular medication or special aids?

If yes, please specify (e.g. glasses, hearing aid etc.):

Has the child suffered any illness that may re-occur?

If yes, please specify (e.g. chronic ear infection):

Has the child had any kind of allergic reactions?

Foods: Penicillin: Yes / No
Others (Insects etc.):
Reaction:

Usual Medical attendant

Doctor's name: Phone No.:
Clinic name:
Address:

Usual Dental attendant

Dentist's name: Phone No.:
Clinic name:
Address:

Medical Benefits cover with:

Ambulance cover with:

Medicare number: Health Care Card number:

SLEEP NEEDS

approx. time(s) and duration:

Cot Bed Special Toy Dummy Bottle (please circle)

How do you settle your child when s/he becomes distressed?

DIET / FEEDING INFORMATION

Bottle Cup Feed self Spoon fed Trainer/Cup (please circle)

Likes:

Dislikes:

Amount:

Times:

