

# ENROLMENT FORMS



## CHILD'S DETAILS

First Name:.....Middle Name:.....Last Name:.....

Other name/s:..... Former name/s:.....

Gender: M  F  Date of Birth\* ...../...../..... Place of Birth.....

The estimated date your child will start school: ...../...../.....

Ethnicity:..... Language Spoken:.....

Religion:.....

Medicare No:.....

Child's CRN\*:.....

Child's Home Address (If different to parent):  
Street Address:.....  
.....  
Suburb:..... State:.....  
Postcode:.....

Are there any Custody or Parenting Orders? Y  N  if yes, please attach a copy of the current order.

Does your child have any additional/special? Y  N   
(if yes, please complete the Additional/Special Needs Application Form)

An additional/special need may include a wide range of physical, sensory and learning disabilities, as well as ongoing illnesses or diagnosed conditions, such as asthma, anaphylaxis, allergies, or other medical conditions.

PARENT/GUARDIAN (Primary Account Holder – This person is registered or likely to register for Child Care Tax Rebate (CCTR) and/or Child Care Benefit (CCB).  
Title: Dr/ Mr /Mrs / Ms / Miss First Name:.....Surname:.....  
Other name/s:.....  
.....  
Relationship to the Child:.....E.g. Mother/Father/Guardian  
CRN\*:..... DOB\*:...../...../.....  
Mobile:..... Home Phone: (.....).  
Home Address:.....  
Suburb:..... State:.....  
Postcode:.....  
Email:.....

Work Details  
Phone:(.....). Street Address:.....  
.....  
Suburb:..... State:.....  
Postcode:.....  
Occupation:.....  
Organisation:.....

\*CRN = Customer Reference Number issued to by DEEWR if you have already registered for Child Care Benefit. If you have not already registered please contact the Family Assistance Office on 13 61 50 to register.

\*DOB = The provision of date of birth information is a mandatory requirement to meet DEEWR eligibility requirements to receive CCTR and/or CCB.



**PARENT/GUARDIAN (Secondary Account Holder)**

Title: Dr /Mr / Mrs / Ms / Miss First Name:..... Surname:.....

Other name/s:.....

Relationship to the Child:..... E.g. Mother/Father/Guardian

DOB:...../...../.....

Mobile:..... Home Phone: (.....).....

Home Address:.....

Suburb:.....

State:..... Postcode:.....

Email:.....

**Work Details**

Phone: (.....)..... Stre

Address:.....

Suburb:..... State:.....

Postcode:.....

Occupation:.....

Organisation:.....

**BOOKING DETAILS**

Date of commencement: ...../...../.....

Proposed Start Date or Due Date (if unborn):...../...../.....

Days/Time Booked (Please indicate the likely drop off and picks times)

Times	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival					
Departure					



## IMMUNISATION

**LITTLE WONDERLAND CHILDCARE** encourages all children to be fully immunised in accordance with the Australian Standard Vaccination Schedule.

You are required to provide proof of immunisation to your Centre Director, so please remember to bring this along with you on your orientation day.

Where there is a genuine reason why children are not, cannot, or will not be immunised please provide a written statement confirming your child's non-immunised status. In the event that there is a suspected or identified vaccine preventable disease, unimmunised children will be excluded from the Centre for the period recommended by the recommended minimum exclusion periods. Children for whom the Centre does not have a complete and/or current immunisation record will be considered unimmunised.

<b>Immunisation Schedule (Please enter vaccination dates)</b>							
<b>Vaccination</b>	<b>0 mths</b>	<b>2 mths</b>	<b>4 mths</b>	<b>6 mths</b>	<b>12 mths</b>	<b>18 mths</b>	<b>4 years</b>
Pneumococcal 23vPCV							
Pneumococcal 7vPCV							
DTPa							
Hep B							
HIB							
IPV							
MMR							
Meningococcal MenCCV							
Oral Poliomyelitis Vaccine							
Chickenpox VZV							



**EMERGENCY CONTACT INFORMATION**

In the unlikely event of an emergency please nominate the persons you would like us to contact.

Child's name:.....

**PARENT/GUARDIAN**

**PARENT/GUARDIAN**

Name:.....  
Name:.....  
Home Phone:(....)..... Home  
Phone:(....).....  
Mobile:.....  
Mobile:.....  
Work Number:(....)..... Work  
Number:(....).....

**EMERGENCY CONTACT AND AUTHORISED TO COLLECT CHILD**

Title: Dr / Mr / Mrs / Ms / Miss  
First Name:..... Surname:..... Relationship to child:.....  
Home Phone:(....)..... Mobile:..... Work  
Phone:(....).....  
Most preferred contact number: Home Phone  Mobile  Work Phone   
Street  
Address:.....  
..  
Suburb:..... State:.....  
Postcode:.....

**EMERGENCY CONTACT AND AUTHORISED TO COLLECT CHILD**

Title: Dr / Mr / Mrs / Ms / Miss  
First Name:..... Surname:..... Relationship to child:.....  
Home Phone:(....)..... Mobile:..... Work  
Phone:(....).....  
Most preferred contact number: Home Phone  Mobile  Work Phone   
Street  
Address:.....  
..  
Suburb:..... State:.....  
Postcode:.....

**EMERGENCY CONTACT AND AUTHORISED TO COLLECT CHILD**

**Title:** Dr /Mr / Mrs / Ms / Miss

First Name:..... Surname:..... Relationship to Child:.....

Home Phone:(....)..... Mobile:..... Work

Phone:(....).....

Most preferred contact number: Home Phone  Mobile  Work Phone

In the unlikely event of an emergency your Child's Doctor and/or Dentist details may be required.

**MEDICAL CONTACTS**

**DOCTOR**

Surgery Name:.....

Name:.....

Phone:(....).....

Phone:(....).....

Street Address:.....

Address:.....

..... Suburb:.....

Suburb:.....

State:..... Postcode:.....

Postcode:.....

**DENTIST**

Surgery

Street

State:.....



**CONSENT FORM**

**PAYMENT AGREEMENT**

I / We agree to:

- ❖ Pay childcare fees as levied by the Centre.
- ❖ Pay fees two (2) weeks in advance or as per direct debit terms.
- ❖ My child's place being withdrawn if my fees are in arrears for more than two (2) weeks and no arrangements have been made with **Centre Director**.
  
- ❖ Fees being charged for booked days that my child does not attend due to illness, holiday or public holidays.
- ❖ Provide two (2) weeks notice prior to withdrawing from the Centre and agree to pay all outstanding fees prior to my departure.
  
- ❖ Be liable for all additional costs incurred by the Centre in collecting the outstanding fees should I fail to pay my fees and my place is withdrawn or I leave the Centre.
- ❖ Pay fees until Child Care Benefit confirmation is received by the Centre.
- ❖ Pay full fees for any non approved absences exceeding the thirty (30) day limit.
- ❖ Submit payment (either by DIRECT-DEBIT, MASTERCARD OR VISA) within seven (7) days of any direct debit faults.

**MEDICAL EMERGENCY**

In case of accident or emergency, every effort will be made to contact the parent/guardian immediately.

In the event that my child requires medical attention, I authorise the Centre Director /Personnel at **LITTLE WONDERLAND CHILDCARE** to obtain/or provide medical, hospital or dental assistance, and agree to pay any medical/transport costs incurred, including ambulance.

Parent/Guardian Signature:.....

Parent/Guardian Name:..... Date: ...../...../.....

**PERMISSION**

I give the Centre Director /Personnel/Management (including students) at Little Wonderland Childcare the authority:

- ❖ To use the name and/or photo of my child for the Centre displays, developmental profiles and/or promotional use, including media; Yes  No
- ❖ To apply sunscreen to my child for outside play; Yes  No
- ❖ To apply parent provided insect repellent to my child for outside play; Yes  No
- ❖ To observe my child to assist in developing an appropriate developmental educational program; Yes  No
- ❖ To allow the people listed as Parent, Guardian and Emergency Contact Persons to drop off and collect my child from the centre unless otherwise specified; Yes  No
- ❖ To allow the people listed a Parent, Guardian and Emergency Contact Persons authorized to drop off and collect my child and to also sign off Medication Records and Accident/incident reports, unless otherwise specified ; Yes  No

PARENT/GUARDIAN  
SIGNATURE:.....

PARENT/GUARDIAN  
NAME:..... Date:...../...../.....



**ADDITIONAL/SPECIAL NEEDS APPLICATION-ASNA**  
**PLEASE COMPLETE THIS FORM IN COLLABORATION WITH YOUR CENTRE DIRECTOR**

It is Little Wonderland Childcare policy to treat each child as an individual, displaying a positive collaborative approach throughout the enrolment as well as teaching/learning processes. We are committed to the inclusion of children with special needs. The ASNA process ensures that the special needs of a child may be adequately evaluated and safely accommodated. An Additional/Special Need may include a wide range of physical, sensory and learning disabilities, as well as ongoing illnesses or diagnosed conditions (such as acute asthma, anaphylaxis etc). For further information please contact our Centre Director.

Date:...../...../.....

**1. Personal Information**

Child's Name: ..... .....  Gender: M  
F

Child's Date of Birth:...../...../..... Child's  
age:.....years.....months

Parent/Guardian  
Names:.....  
.....

Contact ..... Number:  
H(.....).....W(.....).....M.....

Street  
Address:.....  
.....

Suburb:..... State:.....

Postcode:.....

**2. Special/Additional Needs**

Please identify your child's need(s)/condition:

Anaphylaxis  (if your child has Anaphylaxis, please complete the Anaphylaxis Risk Minimisation Plan)

Has this been diagnosed by a health or medical professional: Y  (please attach report)  No

Asthma  (if your child has Asthma, please complete the Asthma Risk Minimisation Plan)  
Has this been diagnosed by a health or medical professional: Yes  No  (please attach report)

Epilepsy  (if your child has Epilepsy, please complete the Epilepsy and Seizures Risk Minimisation Plan)  
Has this been diagnosed by a health or medical professional: Yes  No  (please attach report)

Other, please specify:.....  
...  
Diagnosed by a health or medical professional: Yes  No  (please attach report)  (please complete Action Plan)

Special/Additional Needs details:.....

Is the child currently on medication? Yes  No   
Are the staff required to administer the medication? Yes  No   
If Yes, name of medication:.....  
Dosage:.....  
What other services does the child access(e.g. Early Intervention, Speech Therapy etc)?.....

**3. Enrolment** (please indicate requested attendance by the number of hours each day, below)  
Monday..... Tuesday..... Wednesday..... Thursday.....  
Friday.....  
New application  Existing enrolment   
Date wishing to commence ..... Date child was enrolled ..... Date child commenced .....

\*If enrolment is existing, please indicate the reason for completing the ASNA form at this date(e.g. enrolled prior To diagnosis,etc).....

Please note:Additional information may be required to assist us to assess this application, Your Centre Director Will work with you to collect the necessary information.

## ACTION PLAN

Child's Name:.....

Child's Date of Birth:...../...../.....

Insert Child's

### Details of Child's Medical Condition (Conditions & Symptoms)

- .....
- .....
- .....
- .....
- .....
- .....

- .....
- .....

**Action Plan** (step by step actions to be taken in an event)

- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....

Parent or Guardian contact  
 details: .....

Parent or Guardian  
 Signature: .....

Medical contact  
 details: ..... Date: .../.../.....

Doctors  
 Signature: ..... Date:...../  
 ...../.....