ENROLMENT FORM

Have you registered for CCB (If yes): Account Holder's Name: ....

Account holder's D.O.B………../………../………… (This is a CCMS requirement)

Parent CRN………..

Required Days of Attendance: Mon Tues Wed Thurs Fri

Start Date...

CHILD'S DETAILS

First Name: .... Middle Name: .... Family Name: ....

Former Name/s: .... Child's CRN: ....

Gender: M/F DOB: ..../........../.......... Child's place of birth………..

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

Are there any AVO's in place?...

Have you attached a copy for the centre?..

Are there any court orders? Yes/ No……………………………………………………………………..

If yes, please attach a copy of a current order.

Medicare No.: ....

Health Fund Name and Number……………………………………………………..

PRIMARY ACCOUNT HOLDER (This person is likely to register for Government Assistance)

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

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

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

Home Address: ....

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

Email: ....

Work Details

Phone: (..........) .... Street Address: ....

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

Occupation: .... Organisation: ....

SECONDARY ACCOUNT HOLDER

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

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

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

Home Address: ....

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

Email: ....

Work Details

Phone: (..........) .... Street Address: ....

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

Occupation: .... Organisation: ....

DOB: ..../........../.......... (Provision of date of birth information is a CCMS requirement)

PAYMENT AGREEMENT

I/We understand that:

- Fees are payable two weeks in advance.
- If my fees are in arrears for more than two weeks and no arrangements have been made with the Centre Director, my child's place may be withdrawn.
- Fees will be charged for booked days that my child does not attend due to illness, holiday or public holidays.
- I need to provide two weeks' notice prior to withdrawing from the Centre and agree to pay all outstanding fees prior to my departure.
- Should I fail to pay my fees and the account is referred to a Solicitor or Recovery Agent, then any costs or legal fees incurred will be added to the account and payable by me.
- Two weeks per year holiday half fees can apply only if fees are up to date
- Fees are not charged when the Centre is closed for two weeks at the end of the year.

Parent/Guardian Signature & Name: .... Date: ..../........../..........

Parent/Guardian Signature & Name: .... Date: ..../........../..........
(To be signed by both parents or guardians where applicable)

MEDICAL CONTACTS

Doctor
Surgery Name: ....
Phone: (..........) ....Fax (..........) ....
Street Address: ....
.... Suburb: ....
State: .... Postcode: ....

Dentist
Surgery Name: ....
Phone: (..........) ....Fax (..........) ....
Street Address: ....
.... Suburb: ....
State: .... Postcode: ....

Emergency Contact Information

(Please do NOT include Parent/Guardian Names)

Contact 1

Title: (Dr / Mr / Mrs / Ms / Miss)

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

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

Street Address: ....

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

Contact 2

Title: (Dr / Mr / Mrs / Ms / Miss)

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

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

Street Address: ....

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

Contact 3

Title: (Dr / Mr / Mrs / Ms / Miss)

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

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

Street Address: ....

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

Notes: ....

....

....

MEDICAL EMERGENCY

In the event that my child requires emergency treatment, I authorise the Centre Personnel at TLC Early Learning Centre to seek and to carry out any urgent Medical, Dental, Hospital or Ambulance treatment as we deem necessary for the wellbeing of the child. I agree to pay any Medical, Dental, Hospital and Ambulance costs incurred including transportation.

Parent/Guardian Signature & Name: .... Date:........../........../..........

CHILD SAFETY NOTICE

1. For the health, safety and well-being of all children attending the Centre, please ensure these items are removed from your child's bag:
   - Cigarettes
   - Cigarette lighters
   - Creams
   - Headache tablets
   - Medications (including Panadol & Bonjella)
   - Poisons
   - Safety pins, rubber bands, hair clips, etc.
   - Mobile phones
   - Cosmetics
   - Plastic bags
   - Any other item that could potentially cause harm to a child

2. Please ensure you close all gates behind you at all times and be especially safety conscious of your child in the carpark.

3. It is a legal requirement that each child is signed into and out of the Centre on a daily basis.

PHOTOGRAPHS

From time to time staff may take photographs of the children participating in activities at the Centre or on excursions. Do you give permission for your child to be photographed while participating in the program and for these photographs to be used for promotional purposes.

YES / NO

SIGNED.. Dated: ....

SUNSCREEN

Sunscreen is provided for parents/carers to apply to their child on arrival. If circumstances arise requiring the application of additional protection, I give permission for staff to apply to my child if deemed necessary.

YES / NO

SIGNED.. Dated: ....

INSECT REPELLENT

Insect repellent is provided for parents/carers to apply to their child on arrival. If circumstances arise requiring the application of additional protection, I give permission for staff to apply to my child if deemed necessary.

YES / NO

SIGNED.. Dated: ....

YOUR FAMILY FORM

To enable our Centre Personnel to provide appropriate programs for all children, it is important that we have as much information about each child as possible.

Implementing a multi-cultural, anti-bias approach in early childhood is of top priority at our Centres.

Child's Name: ....

Country of Origin: ....

Language spoken at home: ....

Does your child speak English: ....

Does your child understand English: ....

Would an interpreter to of benefit to the child during the settling in period: ....

What religious or cultural practices would you like your child to observe? (Please give details):

....

Are you or your child Aboriginal or Torres Straight Islander?...

How many family members live with the child? (Older / younger brothers and sisters, grandparents, aunts, uncles, etc.) Please give details:

....

....

Eating patterns: Any special diet or food: ....

....

Family rules: Discipline, affection (Please give details): ....

....

Are there any activities at the Centre which may contravene your family values or beliefs?

....

Could you help us find pictures, posters, artefacts, cookery, dolls, musical instruments, dress-up clothes, or any articles to assist us to share and enhance your culture with the other children in the group? ....

Can you help us provide an insight into your ethnic cultural background? Could you explain jobs, careers, different cultures, stories, music, food, crafts, art, etc. from your country to the children? ....

....

The information you provide us is appreciated.

ASTHMA DETAILS & ACTION PLAN

Child's Name: .... Date: ..../........../..........

Usual Asthma Management Plan

How often does your child have asthma symptoms?

☐ Infrequently (less than five times / year) ☐ Frequently (more than five times / year) ☐ Most days / daily ☐ Usually when exercising

How do you recognise that your child is having asthma attack?

☐ Wheezing (Whistling noise from chest) ☐ Difficulty with breathing ☐ Coughing ☐ Tightness in chest

How do you recognise that your child's asthma is worsening? ....

....

What are your child's asthma triggers (things that make asthma symptoms worse)?.........................

....

Does your child tell you when they need asthma medication? Yes ☐ No ☐

Does your child need assistance to take asthma medication? Yes ☐ No ☐

Does your child take any asthma medication before exercise/play? Yes ☐ No ☐

Medication	Method Used (puffer/inhaler & spacer; nebuliser)	Dose and Frequency

Does your child require asthma medication whilst at the Centre?

Medication	Method Used (puffer/inhaler & spacer; nebuliser)	Dose and Frequency

What reliever medication does your child normally take when asthma symptoms worsen?

Medication	Method Used (puffer/inhaler & spacer; nebuliser)	Dose and Frequency

EMERGENCY ASTHMA MANAGEMENT ACTION PLAN

Medication	Does (E.g. 2 puffs)	Method (E.g. puffer & spacer)	How Often (E.g. every 4 mins)

Additional comments: ....

....

....

....

I have consulted with my child's doctor and authorise the Centre Personnel at TLC Early Learning Centres to follow the Preferred Emergency Action Plan (indicated above) to assist my child in the event of asthma symptoms worsening. I will notify you in writing if there are any changes to these instructions. Please contact me if my child requires emergency treatment or if my child regularly has asthma symptoms.

Parent/Guardian Signature & Name: .... Date: ..../........../..........

ADDITIONAL /SPECIAL NEEDS APPLICATION - ASNA

COMPLETE THIS PAGE IN COLLABORATION WITH YOUR CENTRE DIRECTOR

It is our 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.) 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

Identified need(s)/condition: ....

Diagnosed by a health or medical professional: ☐ Yes (please attach report) ☐ No

Special / Additional Needs details: ....

....

Is the child currently on medication? ☐ Yes ☐ No

Are the staff required to administer the medication? ☐ Yes ☐ No

If so, 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, in the boxes below).**

Please indicate in the boxes the attendance by the number of hours each day	Mon	Tue	Wed	Thur	Fri

☐ New application
Date wishing to commence

........../........../..........

☐ Existing enrolment
Date child was enrolled

........../........../..........

☐ Transferred Enrolment
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 collate the necessary information.**

ALLERGY DETAILS AND ACTION PLAN

Child's Name: .... Date: ..../........../..........

Child's Photo:

Please attach a recent

photograph of your child.

My child has allergies to: ....

My child's Allergy Action Plan

Mild to Moderate Allergic Reaction:

Symptoms: ....

Actions: ....

In the event of an Emergency contact:

My child's doctor is: .... Contact Number: ....

"I give permission for this Allergy Action Plan to be displayed prominently in the Centre"

Parent/Guardian Signature & Name: .... Date: ..../........../..........

PRIVACY CONSENT FORM

In December 2000 an amendment act was passed through the Federal Parliament relating to the Privacy Act. This amendment came into effect on the 21st December 2001.

We require your consent to collect personal information about you and your child/children. Please read this form carefully, and sign where indicated below:

TLC Early Learning Centre collects information from you for the primary purpose of providing quality child care. We require you to provide us with details so that we may properly attend to your child/rens needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our Child Care Centre.
- Billing purposes.
- Disclosure to others involved in child care including the Commonwealth Department of Family Services and the Department of Family and Community Services.
- Disclosure for research and quality assurance activities to improve individual and community child care and practice management.
- Emergency situations whereby staff/hospitals require access to a child/ren's records for appropriate purposes.

I have read the information above and understand the reasons why my and my child/children's information must be collected. I am also aware that TLC Early learning Centre has a privacy policy on handling information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the care and treatment given to my child/ren. I am aware of my right to access the information collected about my child/ren, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I consent to the handling of my information by the Company for the purposes set out above, subject to any limitations on access or disclosure that I notify this Centre of.

Child's Name: ....
(Please print)

Parents Name: ....
(Please print)

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

PARENT STATEMENT

Family Name: ....

Family CRN: ....

Mothers Name: .... D.O.B.: ..../........../..........

Fathers Name: .... D.O.B.: ..../........../..........

1. Complete the section below if you have additional child/ren attending another service in the same week(s), which you will also receive a CCB percentage for. Only indicate one category for each additional child/ren.

1st Child's Name: .... attends this Centre ☐ attends other service ☐

Child's CRN: ....

2nd Child's Name: .... attends this Centre ☐ attends other service ☐

Child's CRN: ....

3rd Child's Name: .... attends this Centre ☐ attends other service ☐

Child's CRN: ....

4th Child's Name: .... attends this Centre ☐ attends other service ☐

Child's CRN: ....

2. Complete the section below if your child has used allowable absentees at another service during the current financial year.

How many allowable absentees have been used: .... days.

Parents Signature: ....

Parents Name: .... Date: ..../........../..........

If you are uncertain on how to complete this form correctly, please ask your Centre Director for assistance.

3. Birth Certificate

Please provide your child's original birth certificate for the Centre Director to sight (or a certified copy of the child's birth certificate, Australian citizenship certificate or passport).

Director Signature..Date: ..../........../..........