Thredbo Early Childhood Centre

Thredbo Community Centre Crackenback Drive THREDBO NSW 2625 Tel: 0264576044

Enrolment Form

Child's Given Name/s: _____ Family Name: _____

Other Names the Child is known by: _____

Other Names the Child has been known by: _____

Gender: M / F DOB: / / Address: _____

Place of Birth: _____ _____

Home Phone: _____

Bill Fees To: Mother / Father / Other Receive Statement of Account via email: Y / N

Legal Guardian: _____ Religion: _____

Indigenous Status: _____ Special Needs: Y / N Disability: Y / N

Cultural Background: _____ Primary Language: _____

Information required to claim CCB:

CCB Hours Nominated: Y / N If Yes - Number of Hours to be used in this Centre _____

Child CRN: | | | | | | | | | | | Claimant CRN: | | | | | | | | | |

Claimant: Mother / Father / Other DOB: / / Name: _____

Claimant Email: _____

Receive Usage Statements via Email: Y / N

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

Work Phone: _____ Hours: _____ Occupation: _____

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

Work Phone: _____ Hours: _____ Occupation: _____

Medical Details:

Does your Child take regular medication or have any disabilities, food sensitivities or allergies we should know about? Y / N

If Yes - Details: _____

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

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

Medicare No: _____ Private Health Particulars: _____

Please supply a copy of your Child's ACIR Immunisation History Statement, ACIR Concientious Objection Form, or ACIR Medical Contraindication Form.

Emergency Details:

Doctor's Name: ______________ Phone: ______________ Contact Doctor: Y / N

Address: ______________________________

Dentist's Name: ______________ Phone: ______________ Contact Dentist: Y / N

Religious Requirements in case of Accident: ______________________________

Nominate at least two people to act on your behalf in the following circumstances:
Pick Up from care; Pick Up in an emergency; Authorisation of medication; Authorisation of excursions

Name: ______________ Relationship to child: ______________

Home Phone: ______________ Mobile Phone: ______________ Work Phone: ______________

Home Address: ______________________________

Work Address: ______________________________

Daily Pick Up: Y / N Emergency Pick Up: Y / N Authorise Medication: Y / N Authorise Excursion: Y / N

Name: ______________ Relationship to child: ______________

Home Phone: ______________ Mobile Phone: ______________ Work Phone: ______________

Home Address: ______________________________

Work Address: ______________________________

Daily Pick Up: Y / N Emergency Pick Up: Y / N Authorise Medication: Y / N Authorise Excursion: Y / N

Name: ______________ Relationship to child: ______________

Home Phone: ______________ Mobile Phone: ______________ Work Phone: ______________

Home Address: ______________________________

Work Address: ______________________________

Daily Pick Up: Y / N Emergency Pick Up: Y / N Authorise Medication: Y / N Authorise Excursion: Y / N

Name: ______________ Relationship to child: ______________

Home Phone: ______________ Mobile Phone: ______________ Work Phone: ______________

Home Address: ______________________________

Work Address: ______________________________

Daily Pick Up: Y / N Emergency Pick Up: Y / N Authorise Medication: Y / N Authorise Excursion: Y / N

Name: ______________ Relationship to child: ______________

Home Phone: ______________ Mobile Phone: ______________ Work Phone: ______________

Home Address: ______________________________

Work Address: ______________________________

Daily Pick Up: Y / N Emergency Pick Up: Y / N Authorise Medication: Y / N Authorise Excursion: Y / N

Please add more Authorised Nominees overleaf if necessary. See Overleaf: Y / N

In the Event of an emergency, illness or accident concerning my child, I consent to the service seeking on my behalf urgent medical, dental, hospital and ambulance services for my child and I consent to the carrying out of appropriate 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.

I understand that the approved provider or nominated supervisor of the service will, as soon as practically possible, notify me or other persons so authorised by me of the accident or illness and the treatment or services arranged for my child.

Parent Signature: ______________________ Date: / /

Family Circumstances:

Is there anyone who is prohibited from having contact with or collecting the child? Y / N

Details: ______________________________

Care Required:

Days Req'd: Mon Tue Wed Thu Fri Hours of Care Req'd: __________ Start Date Req'd: / /

Office Use Only:

Commencement Date: / / Days Attending: Mon Tue Wed Thu Fri

Child's Room or Group: ..... Standard Attendance: .....

Birth Certificate Sighted: Y / Court Order Sighted: Y / Immunisation Details Provided: Y /

Evidence of Priority: Y / Priority No: