Family DAYCARE

Shoalhaven City Council

Enrolment Application

Shoalhaven Family Day Care

Shoalhaven Family Day Care 4/80 Park Rd (P.O Box 42) Nowra, 2541
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Date: ....

1 Applicant - Child Details

First Name: .... Surname: ....

Sex: Male/Female .... DOB: .... Place of Birth: .... Country: ....

Birth certificate sighted by staff member .... Initial ☐

Address: .... Suburb: .... Postcode: ....

Is the child of Aboriginal or Torres Strait Islander descent: Yes/No ....

Cultural background of child: ....

Religion: .... Are there Religious/Dietary requirements? Yes/No ....

If yes, provide details: ....

Description of the child's living situation: ....

....

....

Primary language spoken by the child *(if applicable)*: ....

Child's CRN: ....

2 Parent/Guardian Details 1 - Claiming Child Care Subsidy (CCS)

First name: .... Surname: ....

Previous names or other names known by: ....

D.O.B: ....

Address: .... Suburb: .... Postcode: ....

Phone: .... Mobile: .... Work phone number: ....

Email address for information from service: ....

Occupation: .... Full time /Part time /Casual

Place of Work/Study: ....

Cultural background: ....

Country of Birth: ....

Primary Language spoken at home: ....

CRN: ....

Current copies of any court orders, parenting orders or parenting plans in relation to the child must be provided to Family Day Care. Any additional orders relating to the child's residence or contact with a parent or other person must also be provided.

Privacy Notification: *The information will be used solely by Council staff for the purpose mentioned or a directly related purpose. The applicant understands that this information is provided on voluntary basis and they may apply to Council for access or amendment of the information at any time.*

This form may be published on Council's website in accordance with Government Information (Public Access) Act 2009

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Form Number: 1313	Issue Date: 05/2018
Version Number 5	Next Review date: 06/2020

Parent/Guardian Details 2 continued...

First name: .... Surname: ....

Previous names or other names known by: ....

D.O.B: ....

Address: .... Suburb: .... Postcode: ....

Phone: .... Mobile: .... Work phone number: ....

Email address for information from service: ....

Occupation: .... Full time /Part time /Casual ....

Place of Work/Study: ....

Cultural background: ....

Country of Birth: ....

Primary Language spoken at home: ....

CRN: ....

3 Medical Information

Parent/guardian permission to authorise medical treatment for the child by a registered medical practitioner, hospital or ambulance service and transportation of the child by an ambulance service.

Medical Practitioner/Medical Service

Dr's Name: .... Service: ....

Address: .... Suburb: .... Postcode: ....

Phone: ....

Parent/Guardian permission for a child over preschool age to self administer medication e.g. asthma, anaphylaxis, diabetes

Name/s of other persons who have the authority to authorise consent to administer/self administer medication given by a medical practitioner/medical service as stated in the Family Booklet: ....

Details of any specific healthcare needs of the child, including any medical condition: ....

....

Details of any allergies, including whether the child has been diagnosed at risk of anaphylaxis/asthma: ....

....

Has your child been diagnosed with diabetes? ....

Details of any medical management plan or risk minimisation plan to be followed with respect to a specific healthcare need, medical condition or allergy: ....

....

Staff/Educator has sighted child health records relating to the above: Yes / No

Staff/Educator has given parent/Guardian copy of relevant health policy: Yes / No

Childs Medicare number: ☐☐☐☐ ☐☐☐☐☐ ☐ ☐

Are you a member of a health fund? Yes/No ....

Health Fund name: ....

Are there any special considerations/additional needs of your child we should know about? Yes/No

If yes, please give details: ....

Medical Information continued...

Details of any dietary restrictions for the child: ....

....

Is your child immunised? Yes / No

Staff copy immunisation? Yes / No

4 Authorisations

Should an emergency arise necessitating medical or dental attention for my child, I give permission for this to be obtained, and **agree that I shall be responsible for the cost of any medical treatment, including Ambulance call out.**

Parent/Guardian Signature & Date : ....

In the event of an emergency we will attempt to contact parents/guardians as listed above. If we are unable to make contact we will attempt to contact your emergency contacts listed.

To assist us to deal with these situations, one of the following people authorised to collect and care for your child after an accident, injury, trauma or while they are ill will be notified. The emergency contacts listed on this form are the only people who can collect your child/ren if you cannot collect them yourself. All emergency contacts must be over 16 years of age. At least one emergency contact is required.

The below emergency contacts have my consent to authorise the medical treatment of my child, for the approved provider, a nominated supervisor or an educator to seek:

- Medical treatment for the child from a registered medical practitioner, hospital or ambulance service; and
- Transportation of the child by an ambulance service

Authorised Nominee in an Emergency

In an **emergency**, if parents/guardians cannot be contacted, please nominate an authorised nominee:

First name: .... Surname: ....

Address: .... Suburb: .... Postcode: ....

Phone: .... Mobile: ....

Place of employment: *(optional)* .... Email: ....

Relationship to Child: ....

Authorised nominee for collection of child from care

Please list adults with permission to collect child from care in addition to enrolling parents/guardians:

1) First name: .... Surname: ....

Address: .... Suburb: .... Postcode: ....

Phone: .... Mobile: ....

Place of employment: *(optional)* .... Email: ....

Relationship to Child: ....

2) First name: .... Surname: ....

Address: .... Suburb: .... Postcode: ....

Phone: .... Mobile: ....

Place of employment: *(optional)* .... Email: ....

Relationship to Child: ....

5 Health information

Do you have any concerns relating to your child's development? Yes / No

If yes, please provide details: ....

Are you currently using any Additional Needs or Early Intervention Services for your child? Yes / No

If yes, please provide details: ....

I give permission for Shoalhaven Family Day Care to network with these services: Yes / No

Permission to apply Nappy Creams

I, ... give permission for the regular, or back up,
Educator to apply any nappy cream or lotion that I provide. The cream or lotion is to be applied at nappy change when required. Any cream or lotion that I provide is to be administered according to manufacturer's / doctor's directions.

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

Permission to apply Sunscreen

I, ... give permission for the regular, or back up, Educator to apply 30+ sunscreen to my child. Signed: .... Date: ....

EITHER: I give permission for the regular, or back up, Educator to apply any brand of sunscreen Either: Signed: .... Date: ....

OR: I give permission for the regular, or back up, Educator to apply (please name brand) .... Or: Signed: .... Date: ....

I agree to ensure that the regular, or back up, Educator is supplied with this sunscreen as necessary Signed: .... Date: ....

Permission to apply Teething Gels

I, ... give permission for the regular, or back up, Educator to apply teething gel which I will supply. I understand the gel will be administered in accordance with the manufacturer's directions. Signed: .... Date: ....

5 I am aware:

Sometimes children are taken on regular outings eg playsession & excursions.

Written authorisation must be provided: ☐

***Child Protection* - All staff and educators at Shoalhaven Family Day Care are mandatory reporters.** ☐

6 Child Care Subsidy (CCS)

The cost of child care can be reduced by applying for Child Care Subsidy.

Please ask staff for information.

Parent Statement

Do you have a child attending this service who is also attending another approved Child Care Service? Yes/No

Does the child attending this service have a sibling who is attending another approved Child Care Service? Yes/No

Are you related to any Educator with Shoalhaven Family Day Care? Yes/No

If yes please name ....

My preferred method for the Co-ordination Unit to contact me is *(please number one or more boxes, with 1 being the preferred method)*

Home phone number ☐ Work phone number ☐ Mobile phone number ☐ Written correspondence ☐ Email ☐

1. Parent/Guardian Signature & Date

Name: ....

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

2. Parent/Guardian Signature & Date

Name: ....

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

Are you or your partner a Family Day Care Educator? ☐ Yes ☐ No

I will contact Shoalhaven Family Day Care if myself or my partner become an educator with any Family Day Care Service.

I have read the above legislative requirement

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