Please attach a passport size photo of your child here.

OFFICE USE ONLY

Date entered into system: _____

Date of Commencement: _____

Signed by: _____

ENROLMENT FORM

CHILD'S DETAILS					
First name		Middle name		Surname	
Sex	Male Female		Date of Birth		
Any former or other names the child is known by					
Previous School attended (If applicable)					
Child's nationality/ethnicity			Language spoken at home		

Does your child suffer a Chronic Illness? (e.g. asthma, anaphylaxis, diabetes) YES NO
If **YES** please ask your doctor to complete the Chronic Illness Management Form (*please attach copy*).

PARENT DETAILS:			
Legal Guardian / Parent 1:		**Parent 2:**	
Last name		Last name	
First Name		First Name	
Other or former names		Other or former names	
Date of Birth		Date of Birth	
Address		Address	
Home Tel No		Home Tel No	
Work Tel No/s		Work Tel No/s	
Mobile		Mobile	
Work Address		Work Address	

Occupation		Occupation	
Country of Birth		Country of Birth	
Language spoken at home		Language spoken at home	
Email address		Email address	

OTHER CHILDREN IN THE FAMILY		
Name	Date of Birth	Does this child attend childcare or school (*please list)*

CHILD'S MEDICAL AND HEALTH INFORMATION	
Medical Practitioner / Medical Service Name..... Address..... Tel.....	Child's Pediatrician/Specialist: Name..... Address..... Tel.....
Has your child ever been diagnosed at risk of: Anaphylaxis YES NO . Asthma YES NO . Allergies YES NO . Diabetes YES NO . Eczema YES NO . Convulsions YES NO . Epilepsy YES NO .	Please provide details*
Does your child have any other medical condition or other health care needs? YES NO .	Please provide details*
Does the medical condition require a medical	If you have answered yes to any of the above questions a copy of a current medical plan must

plan? YES NO	be provided and regularly updated.
Does your child take regular medication? YES NO	Please provide details*
Are there any dietary restrictions? YES NO	Please provide details*
Is your child immunised? YES NO Undergoing	Please provide copy of current immunisation record and updates. *
Definition of a child with a Disability Does this child have a need for additional assistance in any of the following areas, compared to children of a similar age, that is related to an underlying long-term (lasting for more than 6 months) health condition or disability? o Learning and applying knowledge, education o Communication o Mobility o Self-care o Interpersonal interactions and relationships o Other – including general tasks, domestic life, community and social life **Does your child have a Disability?** YES NO Date diagnosed	**Definition of a child with Special Needs** Children with special needs are those from the priority groups listed below: o Children from culturally and linguistically diverse backgrounds o Children with a refugee background who have been subjected to trauma Indigenous children o The child's place has been sought by a state or territory child protection worker o The child is in the care of the state, or other forms of out of home care **Does your child identify with Special Needs** YES NO Date diagnosed

* Attach a separate page if necessary.

AUTHORISATIONS

I give permission to the Educator and staff of ACAE to contact the following people to collect my child and/or advise on the welfare of the child in the event of an emergency. I will give PRIOR notice to the ACAE for these people to collect my child.

In the event of an emergency the educator and/or staff will always attempt to contact the parents first before contacting the names below.

Please note that where consent is given to someone other than a parent to collect a child in an emergency they should be able to collect the child within 30 minutes of being called.

Any emergency contact must produce satisfactory identification when collecting the child and must sign the attendance record.

AUTHORISED NOMINEES (contacts additional to parents/guardians). Please complete all details.

1st Contact	**2nd Contact**
Last name.....	Last name.....
First Name.....x.....	First Name.....
Address.....	Address.....
.....	.....
Home Tel No.....	Home Tel No.....
Work Tel No/s.....	Work Tel No/s.....
Mobile.....	Mobile.....
Relationship to Child.....	Relationship to Child.....
Collect child YES NO	Collect child YES NO
Emergency contact YES NO	Emergency contact YES NO
Consent to medical treatment / authorise administration of medication YES NO	Consent to medical treatment / authorise administration of medication YES NO
Authorise excursions YES NO	Authorise excursions YES NO
3rd Contact	**4th Contact**
Last name.....	Last name.....
First Name.....	First Name.....
Address.....	Address.....
.....	.....
Home Tel No.....	Home Tel No.....
Work Tel No/s.....	Work Tel No/s.....
Mobile.....	Mobile.....
Relationship to Child.....	Relationship to Child.....
Collect child YES NO	Collect child YES NO
Emergency contact YES NO	Emergency contact YES NO
Consent to medical treatment / authorise administration of medication YES NO	Consent to medical treatment / authorise administration of medication YES NO
Authorise excursions YES NO	Authorise excursions YES NO

ACAE & PARENT AGREEMENT

Parent / Guardian name:

Child's full name:

Parent's Agreement	Parent's Initial
I agree to abide by the fees, charges, and conditions set down by ACAE.	
I agree to follow the ACAE Policy and Procedures.	
I acknowledge that normal fees are due on Public Holidays, if these days fall within the normal school operating period.	
I agree to notify the ACAE office of any changes to my working status, address, telephone number, emergency contacts, immunisation, health care plans and any other information relevant to my child's care.	
I understand that I must sign my child/ren in and out of care every time my child is delivered to and collected from care. I acknowledge that I must sign the correct and exact time on the attendance record each time my child enters and leaves care.	
In the event of my child contracting an infectious disease, I shall not send him/her to the educator until the exclusion period recommended by the Health Department has expired, but I shall pay any fees due in accordance with the ACAE Fees. I understand that I will need to provide clearance letter from the doctor, when returning to care. I understand that a child whose immunisation record has not been provided to the ACAE or who is not immunised will be excluded from care in the event of an outbreak of a vaccine preventable disease.	
I agree to notify the ACAE office, and educators, of any change in the health of my child that requires a specific health management plan (e.g. Asthma, Anaphylaxis, Allergies, Diabetes, and Intolerances).	
I agree to supply immunisation records to the ACAE each time my child/ren's immunisation is updated.	
In case of accident or other emergency resulting in the need of immediate medical, dental or hospital treatment. I hereby give my permission for the educator to arrange for my child to be seen by a doctor and/or dentist, treated at the nearest hospital, or transported unaccompanied by ambulance to the nearest most appropriate medical facility. I agree to pay all costs incurred.	
I acknowledge that the ACAE educators will take all reasonable and necessary steps to provide an adequate standard of care for the child whilst in the care of the educator. I also acknowledge that my child may experience accidental injury or illness through no fault of the educator/staff whilst with the educator, in spite of the efforts of the educator.	
I **DO / DO NOT** (*please circle*) consent to my child/ren being photographed for newspaper publication, ACAE website, ACAE Facebook and newsletter for advertising	

the service and/or educator's/ACAE photographic album.	
I understand, that registration fees is non-refundable and any fees paid in advance to the service, will not be refunded, unless 4 weeks' notice of leave is given to ACAE.	
If fees are in arrears, for maximum of one month, ACAE will follow up with the parents and if parent does not respond or negotiate the fees with ACAE, I understand that, my child's position for care at ACAE will be compromised, and will be given to another child.	
I agree to my child being observed to check their development. If my child needs specialist testing, I will be asked for my permission first.	
I understand that my child's pictures will be taken as individual or in-group experience for daily reflection, observation, evaluation, children's portfolio and any other documentations required by ACAE educators.	
I acknowledge that 4 weeks' notice must be given to ACAE in regards to, termination of care. This change must be recorded on the appropriate form and signed by both the ACAE and parent.	
I understand that I am to provide adequate changes of clothes and hat for my child, appropriate to the climate.	
I understand that any breach of this contract may result in termination of care arrangement.	

Signature (Parent/Guardian): Date:

ACAE representative Signature: Date:

OFFICE USE ONLY	
Documents checklist (*please attach copy*)	Birth Certificate/Passport /Citizenship Illness management plan (if applicable) Current Immunisation . Passport size photo