

Educator first name: \_\_\_\_\_ Educator surname: \_\_\_\_\_

Date care is to commence: \_\_\_\_\_ Date care is to cease (if known): \_\_\_\_\_

## PARENT / GUARDIAN ONE (This must be the parent/guardian who receives subsidies from Centrelink)

First name: \_\_\_\_\_ Surname: \_\_\_\_\_

Address: \_\_\_\_\_ Post code: \_\_\_\_\_

Mailing address: \_\_\_\_\_ Post code: \_\_\_\_\_

Contact phone 1: \_\_\_\_\_ Contact phone 2: \_\_\_\_\_

Email: \_\_\_\_\_

This email address will be used to send a fortnightly payment advice with a breakdown of your fees for that fortnight.

Date of birth: \_\_\_\_\_ Parent Customer Reference Number (CRN): \_\_\_\_\_

*N.b, a Parent Customer Reference Number (CRN) is necessary in order to claim any Centrelink subsidies. This must be unique.*

Employment status:  Full Time  Part Time  Not Working

Reason for use of this service:  Work  Study  Recreation  Respite

Occupation: \_\_\_\_\_ Workplace: \_\_\_\_\_

Country of birth: \_\_\_\_\_ Origin:  Aboriginal  Torres Strait Islander  Both  Neither

Is English the primary language spoken at home?  Yes  No If no, please specify: \_\_\_\_\_

## PARENT / GUARDIAN TWO

Do you wish for this parent/guardian to be the second point of contact?  Yes  No

First name: \_\_\_\_\_ Surname: \_\_\_\_\_

Address: \_\_\_\_\_ Post Code: \_\_\_\_\_

Contact phone 1: \_\_\_\_\_ Contact phone 2: \_\_\_\_\_

Email: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Employment status:  Full Time  Part Time  Not Working

Occupation: \_\_\_\_\_ Workplace: \_\_\_\_\_

Country of birth: \_\_\_\_\_ Origin:  Aboriginal  Torres Strait Islander  Both  Neither

*If either parent/guardian is a registered Family Day Care Educator, please complete the specified information request form.*

## OFFICE USE ONLY

Application fee paid Date: \_\_\_\_\_ Receipt no.: \_\_\_\_\_ Signature: \_\_\_\_\_

## EMERGENCY CONTACTS

Emergency contacts listed below will be contacted in the event that the parent/guardian cannot be reached. Children cannot be released into the custody of persons not listed on this form. Please complete all fields for each emergency contact accurately, as proof of identification will be asked when children are collected by persons unknown to the educator.

First name: \_\_\_\_\_ Surname: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_ Post code: \_\_\_\_\_

Contact phone 1: \_\_\_\_\_ Contact phone 2: \_\_\_\_\_

Email: \_\_\_\_\_

*Emergency contact email addresses are only required if your educator operates using Harmony Web.*

Is the above listed person authorised to:

- Collect your child/children?	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Administer medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Participate in excursions?	<input type="checkbox"/> Yes <input type="checkbox"/> No

First name: \_\_\_\_\_ Surname: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_ Post code: \_\_\_\_\_

Contact phone 1: \_\_\_\_\_ Contact phone 2: \_\_\_\_\_

Email: \_\_\_\_\_

*Emergency contact email addresses are only required if your educator operates using Harmony Web.*

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- Collect your child/children?	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Administer medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Participate in excursions?	<input type="checkbox"/> Yes <input type="checkbox"/> No

First name: \_\_\_\_\_ Surname: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_ Post code: \_\_\_\_\_

Contact phone 1: \_\_\_\_\_ Contact phone 2: \_\_\_\_\_

Email: \_\_\_\_\_

*Emergency contact email addresses are only required if your educator operates using Harmony Web.*

Is the above listed person authorised to:

- Collect your child/children?	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Administer medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Participate in excursions?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## DOCTOR'S DETAILS

Doctor's name: \_\_\_\_\_ Contact number: \_\_\_\_\_

Medical centre address: \_\_\_\_\_ Post code: \_\_\_\_\_

## CHILD FOR WHOM CARE IS REQUIRED

Child first name: \_\_\_\_\_ Child surname: \_\_\_\_\_ Sex:  Male  Female

Address (if different from parent): \_\_\_\_\_ Post code: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Date care is to commence: \_\_\_\_\_

Child Customer Reference Number (CRN): \_\_\_\_\_

*N.b, a Child Customer Reference Number (CRN) is necessary in order to claim any Centrelink subsidies. This must be unique.*

Medicare number: \_\_\_\_\_

Country of birth: \_\_\_\_\_ Origin:  Aboriginal  Torres Strait Islander  Both  Neither

Is English the primary language spoken at home?  Yes  No If no, please specify: \_\_\_\_\_

Are there any family court orders / parent orders / parenting plans for this child?  Yes  No

*If yes, please complete the family court order / parenting orders / parenting plan form.*

Do you give permission for Kath Dickson Family Day Care educators and staff to seek medical assistance in the event of an emergency, and for your child to be transported in an ambulance if necessary?  Yes  No

Has your child had any major injuries in the past?  Yes  No If yes, please list: \_\_\_\_\_

Does your child have any diagnosed medical conditions? E.g., allergies, dietary restrictions, asthma, anaphylaxis:  Yes  No

*If yes, a medical management plan must be completed for your child.*

Does your child require additional assistance? E.g., learning, applying knowledge, communication, mobility:  Yes  No

*If yes, please specify:* \_\_\_\_\_

Does your child have any additional needs? E.g., religious, cultural, subject to trauma, linguistic diversity:  Yes  No

*If yes, please specify:* \_\_\_\_\_

## CHILD CARE CENTRE / KINDERGARTEN / PREP / SCHOOL ATTENDED (IF APPLICABLE)

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Post code: \_\_\_\_\_

Days and hours attended: \_\_\_\_\_ Who is responsible during these hours? \_\_\_\_\_

Does your child require educator transport to and from the above location?  Yes  No

By signing below, you declare that you understand and agree to the following conditions:

- Upon application, you automatically become a member of the Kath Dickson Family Centre Association.
- Your placement is open to review by the service in accordance with the Child Care Management System Handbook's *Priority of Access*.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Information on this form is a requirement in accordance with section 160 of the Education and Care Services National Regulations 2011. Unfortunately, incomplete forms are not able to be processed. Thank you for taking the time to complete this application.*