



***Child 's Details***

Surname: \_\_\_\_\_ First Name/s: \_\_\_\_\_

Other Name/s: \_\_\_\_\_ Any Former Name/s \_\_\_\_\_

Child 's Residential Address: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender ( please circle ) : Male Female

Place of Birth: \_\_\_\_\_ Aboriginal or Torres Strait Islander origin ( please circle ) : Yes No

Cultural Identity or Ethnic Group: \_\_\_\_\_ Primary Language Spoken: \_\_\_\_\_

***Parent/Guardian Details***

<u>Details</u>	<u>Mother/Guardian 1</u>	<u>Father/Guardian 2</u>
Name:		
Other Name/s:		
Residential Address:		
Telephone No ( Home ) :		
Telephone No ( Work ) :		
Telephone No ( Mobile ) :		
Email:		
UHF Channel:		
Aboriginal/Torres Strait Islander:	Yes / No	Yes / No
Work Name & Address:		

***Emergency Contact*** ( This should be someone other than the parent/guardian listed above )

<u>Details</u>	<u>Emergency Contact 1</u>	<u>Emergency Contact 2</u>
Name:		
Residential Address:		
Telephone No ( Home ) :		
Telephone No ( Work ) :		
Telephone No ( Mobile ) :		
Relationship to Child:		

**Authority to Collect** (Please nominate any other people who will collect your children from the HMCS )

<u>Details</u>	<u>Contact 1</u>	<u>Contact 2</u>
Name:		
Address:		
Telephone ( Home ) No:		
Telephone ( Work ) No:		
Telephone ( Mobile ) No:		
Relationship to Child:		

<u>Details</u>	<u>Contact 3</u>	<u>Contact 4</u>
Name:		
Address:		
Telephone ( Home ) No:		
Telephone ( Work ) No:		
Telephone ( Mobile ) No:		
Relationship to Child:		

**Information about your family...**

Siblings Names and Ages : \_\_\_\_\_

Extended Family Members living with you : \_\_\_\_\_

Other languages spoken at home : \_\_\_\_\_

Any special cultural/ethnic beliefs or celebrations/religious needs that you feel the staff may need to know about : \_\_\_\_\_

**Court Order/Custody Information**

Are there any court orders affecting the child ( please circle )?    Yes    No

If yes, please provide details ( including a photocopy of the Order for Centre records ) : \_\_\_\_\_

Please describe any custody or access arrangements : \_\_\_\_\_

\_\_\_\_\_

**HMCS Information**

What is your nearest town ? \_\_\_\_\_

How far from your place of residence ( house ) to the nearest town ? \_\_\_\_\_ kms

How far from your place of residence ( house ) to the nearest childcare service ( other than HMCS ) ?  
\_\_\_\_\_ kms Name of Service - \_\_\_\_\_

What HMCS services would you use if available in your area ( please tick ) ?

Venue Care

Farm Based Care

Please tick which venue care you will access (you may tick more than one):

Booligal

Maude / Hay

Clare

Carrathool

Goolgowi

Coleambally

**Additional information for the HMCS staff**

I/We agree to have our child ( insert name ) \_\_\_\_\_ being photographed during activities  
& routine times for the purpose of displays within the HMCS venue of care, to be used in observations, displayed in other children' s portfolios, and internal and external promotion.

Signature of Parent/Guardian : \_\_\_\_\_ Date : \_\_\_\_\_

Does your child have any specific problems that the childcare staff members need to be aware of?  
\_\_\_\_\_

Does your child have any specific interest? \_\_\_\_\_

What may help your child to settle at drop off? \_\_\_\_\_

Does your child have any preferred toys or comforters when upset or tired? \_\_\_\_\_

Do you have any requests in regards to your child 's care (ie. what time the child eats, sleeps, toileting etc. )? \_\_\_\_\_

Any additional information?  
\_\_\_\_\_

**Medical Information**

Child 's Medicare No : \_\_\_\_\_

Private Health Fund Details ( if applicable ) : \_\_\_\_\_

Health Care Card ( please circle )      Yes      No      if Yes expiry date \_\_\_\_\_  
( please note if you hold a current Health Care Card you are eligible for reduced fees and staff at HMCS will provide you with the necessary form to complete)

**Doctor**

Child 's Doctor 's Name : \_\_\_\_\_ Phone : \_\_\_\_\_

Surgery Address : \_\_\_\_\_

**Dentist**

Child 's Dentist 's Name : \_\_\_\_\_ Phone : \_\_\_\_\_

Surgery Address : \_\_\_\_\_

**Medical History**

Has your child suffered from any of the diseases listed below ( please circle ) :-

Measles: Yes/No      German Measles: Yes/No      Mumps: Yes/No      Chicken Pox: Yes/No

Is your child 's immunisation up to date? Yes/No  
( Please provide a copy of your child 's current immunisation history statement.

If your child is not immunised, please state reasons why?

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I/We understand that in the event of an outbreak of a vaccine preventable disease at the centre, the Management is required to notify the Department of Health of any un-vaccinated children enrolled at the centre. I hereby give permission for my child to be excluded from attendance for such time as the Department deems necessary.

Signature of Parent/Guardian : \_\_\_\_\_ Date : \_\_\_\_\_

Please state particulars of any relevant medical history ( including hospitalisation ) : \_\_\_\_\_

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**Medication**

Does your child regularly receive any medication? Yes/No

Name of medication : \_\_\_\_\_ Prescribed for : \_\_\_\_\_

( If you require the HMCS staff to administer medication, please complete the HMCS Medication form )

Does your child suffer from Asthma? Yes/No ( If yes, we will require an Action Plan from your doctor )

Does your child suffer from Epilepsy? Yes/No ( If yes, we will require an Action Plan from your doctor )

Does your child suffer from any allergies? Yes/No ( If yes, we will require an Action Plan from your doctor )

Allergy/Allergies : \_\_\_\_\_

Reaction : \_\_\_\_\_

Symptoms : \_\_\_\_\_

Treatment : \_\_\_\_\_

- If your child is Anaphylactic we will require an Action Plan from your doctor.
- If you child is Asthmatic we will require an Action Plan from your doctor.

**Administer Medication Consent**

I/We give permission for the HMCS staff ( including personnel employed by HMCS ) to administer the following:-

Paracetamol ( in the case of fever, etc ): Yes/No

Sunscreen / Insect Repellent ( when appropriate ): Yes/No

Signature of Parent/Guardian : \_\_\_\_\_ Date : \_\_\_\_\_

**Medical Emergency Consent**

In the event of a medical emergency I hereby authorise the staff of Hay Mobile Children 's Service to :-

1. Seek urgent medical, hospital, dental or ambulance service for my child should the need arise;
2. Allow appropriate medical, dental, ambulance and hospital treatment to be carried out should the need arise;

Name of Parent/Guardian : \_\_\_\_\_

Signature : \_\_\_\_\_ Date : \_\_\_\_\_

***Head lice Consent***

To support parents/carers and the broader community to achieve a consistent, collaborative approach to head lice management, I/we (insert name ) \_\_\_\_\_ consent to HMCS staff conducting regular checks for head lice on my/our child.

Signature of Parent/Guardian : \_\_\_\_\_

***Declaration***

I/We (insert name ) \_\_\_\_\_ have read and will adhere to the policies referred to in the parent handbook. All information I have provided to the HMCS is true and correct.

Parent/Guardian Signature : \_\_\_\_\_ Date : \_\_\_\_\_

Parent/Guardian Signature : \_\_\_\_\_

Date : \_\_\_\_\_

**Please Note:**

**In accordance with New South Wales Department of Education requirements copies of Birth Certificates and Immunisation History Statements must be provided on enrolment.**

***Membership to Association***

As an Incorporated Association, Hay mobile Children ' s Service has the option to offer membership to Parents/Guardians of children that utilise the service. Please complete the following if you would like to be a paid member of the Association.

I/We (insert name ) \_\_\_\_\_ .

Date : \_\_\_\_\_

Signature : \_\_\_\_\_

## CONSENT TO USE AND DISCLOSURE OF CHILD'S PERSONAL INFORMATION.

I understand that Hay Mobile Children's Service (hereafter noted as Service) will collect my child or legal ward's (as identified below) personal information.

Personal information (including information or an opinion) may include information that I provide (or someone provides on my behalf) as part of my Child's enrolment application or as part of an application for funding for my Child or otherwise in connection with the Child's attendance at the Service, including the Child's name, date of birth, and sensitive information such as information relating to the Child's health including any disability (this may include medical records and reports).

I authorise the Service to disclose my Child's Personal Information to the New South Wales Department of Education and Communities (hereafter noted as Department). I understand that the Department will only use or disclose such Personal Information relating to the Child as permitted under applicable privacy laws including the *Privacy and Personal Information Protection Act 1998* (NSW). In limited circumstances this may include disclosure to other Australian government agencies, including the Commonwealth and to those located in States and Territories outside New South Wales.

The Department may use my Child's Personal Information for any purpose relating to the exercise of its governmental functions including for, but not limited to, the assessment and potential provision of support or funding to my child or the Service including for any teachers or caregivers in connection with the Service.

If you do not agree to your Child's Personal Information being provided to the Department then this could impact the funding allocation made available to the Service.

Under law, you may have a right of access to, and correction of, such Personal Information. Please contact the Service or the Department in such circumstances.

I consent to the collection, use and disclosure of my Child's Personal Information in the manner outlined in this form.

DETAILS OF CHILD	
PRINT FULL NAME OF CHILD	
DATE OF BIRTH	

DETAILS OF PARENT / LEGAL GUARDIAN	
PRINT FULL NAME OF PARENT / LEGAL GUARDIAN	
RELATIONSHIP TO CHILD (i.e. mother, father, guardian)	

**SIGNATURE OF PARENT / GUARDIAN**

**DATE**

\_\_\_\_\_

\_\_\_/\_\_\_/\_\_\_