



St Hilda's Anglican School for Girls Extend-ED Program 2018

Child/Children Details

Child 1

First Name: _____ Family Name: _____ Date of Birth: _____

Address: _____

Gender: _____ Language Spoken: _____

Cultural Background: _____ Cultural or Religious Requirements: _____

Child 2

First Name: _____ Family Name: _____ Date of Birth: _____

Address: _____

Gender: _____ Language Spoken: _____

Cultural Background: _____ Cultural or Religious Requirements: _____

Child 3

First Name: _____ Family Name: _____ Date of Birth: _____

Address: _____

Gender: _____ Language Spoken: _____

Cultural Background: _____ Cultural or Religious Requirements: _____

Child 4

First Name: _____ Family Name: _____ Date of Birth: _____

Address: _____

Gender: _____ Language Spoken: _____

Cultural Background: _____ Cultural or Religious Requirements: _____

Parent/Guardian Details

Parent 1

First Name: _____ Family Name: _____

Address: _____

Email: _____

Mobile: _____

Home: _____

Work: _____

Authorised to pick up child from Extend-ED Yes/No (please circle)

Parent 2

First Name: _____ Family Name: _____

Address: _____

Email: _____

Mobile: _____

Home: _____

Work: _____

Authorised to pick up child from Extend-ED Yes/No (please circle)

Custody of Child/Children

Have any court orders been made by a court regarding your child?
If yes please provide a photocopy of these orders for Extend-ED.

Yes/No

Emergency Contact 1

When the parent cannot be contacted and notified

First Name: _____ Family Name: _____

Address: _____

Mobile: _____

Other: _____

Relationship to Child: _____

Emergency Contact 2

When the parent cannot be contacted and notified

First Name: _____ Family Name: _____

Address: _____

Mobile: _____

Other: _____

Relationship to Child: _____

Authorised Persons to Collect Child/Children from Extend-ED

Authorised Persons 1

First Name: _____ Family Name: _____

Address: _____

Mobile: _____

Other: _____

Relationship to Child: _____

Authorised Persons 2

First Name: _____ Family Name: _____

Address: _____

Mobile: _____

Other: _____

Relationship to Child: _____

Authorised Persons 3

First Name: _____ Family Name: _____

Address: _____

Mobile: _____

Other: _____

Relationship to Child: _____

Authorised Persons to Consent to Medical Treatment, the Administration of Medication and to authorise an educator to take the child outside the education centre

Authorised Persons 1

First Name: _____ Family Name: _____

Address: _____

Mobile: _____

Other: _____

Relationship to Child: _____

Authorised Persons 2

First Name: _____ Family Name: _____

Address: _____

Mobile: _____

Other: _____

Relationship to Child: _____

Authorised Persons 3

First Name: _____ Family Name: _____

Address: _____

Mobile: _____

Other: _____

Relationship to Child: _____

Child/Children Health Details

Child 1

Child's Registered Medical Practitioner

Doctor's Name: _____

Name and Address of the Medical Centre: _____

Contact Number: _____

Medicare Number: _____ Position on Medicare Card: _____ Expiry Date: _____

Immunisation Status

Is the child's immunisation up to date? Yes/No

Please provide a copy

Does your child/Children require regular medication Yes/No

If yes, please give details.

Does your child/Children have known allergies? Yes/No

If yes, please provide current action plan to be taken in the event of an allergic reaction.

Does your child/Children have any special dietary requirements?

Yes/No **If yes, please provide details.**

Does your child/Children suffer from asthma? Yes/No

If yes, please provide details of medication required and fill out an asthma plan for the Centre.

Child 2

Child's Registered Medical Practitioner

Doctor's Name: _____

Name and Address of the Medical Centre: _____

Contact Number: _____

Medicare Number: _____ Position on Medicare Card: _____ Expiry Date: _____

Immunisation Status

Is the child's immunisation up to date? Yes/No

Please provide a copy

Does your child/Children require regular medication Yes/No

If yes, please give details.

Does your child/Children have known allergies? Yes/No

If yes, please provide current action plan to be taken in the event of an allergic reaction.

Does your child/Children have any special dietary requirements?

Yes/No **If yes, please provide details.**

Does your child/Children suffer from asthma? Yes/No

If yes, please provide details of medication required and fill out an asthma plan for the Centre.

Child 3

Child's Registered Medical Practitioner

Doctor's Name: _____

Name and Address of the Medical Centre: _____

Contact Number: _____

Medicare Number: _____ Position on Medicare Card: _____ Expiry Date: _____

Immunisation Status

Is the child's immunisation up to date? Yes/No

Please provide a copy

Does your child/Children require regular medication Yes/No

If yes, please give details.

Does your child/Children have known allergies? Yes/No

If yes, please provide current action plan to be taken in the event of an allergic reaction.

Does your child/Children have any special dietary requirements?

Yes/No **If yes, please provide details.**

Does your child/Children suffer from asthma? Yes/No

If yes, please provide details of medication required and fill out an asthma plan for the Centre.

Child 4

Child's Registered Medical Practitioner

Doctor's Name: _____

Name and Address of the Medical Centre: _____

Contact Number: _____

Medicare Number: _____ Position on Medicare Card: _____ Expiry Date: _____

Immunisation Status

Is the child's immunisation up to date? Yes/No

Please provide a copy

Does your child/Children require regular medication Yes/No

If yes, please give details.

Does your child/Children have known allergies? Yes/No
If yes, please provide current action plan to be taken in the event of an allergic reaction.

Does your child/Children have any special dietary requirements?
Yes/No **If yes, please provide details.**

Does your child/Children suffer from asthma? Yes/No
If yes, please provide details of medication required and fill out an asthma plan for the Centre.

AUTHORISATION

1. PERMISSION FOR STAFF TO ACT IN CASE OF AN EMERGENCY OR ACCIDENT

Although every care will be taken of your child while at Extend-ED, the staff can in no way be held responsible for any accident which may occur. In the event of an accident, or illness requiring emergency medical treatment, every effort will be made to contact the parents before such treatment is sought. However, should this prove impossible, it will be necessary for authority to be given for the treatment to be undertaken. All medical and transport expenses will be the responsibility of the parent/guardian should they be necessary. Parents are asked to complete and sign the following:

I _____ authorise the staff of St. Hilda's Extend-ED to seek emergency medical treatment or transport for my child/Children _____ should this be considered necessary.

NAME: _____ **SIGNED:** _____

DATE: _____

CONDITIONS OF ENROLMENT

1. A staff member must be notified of the arrival and departure of children at the Extend-ED. All children are to be signed in and out by an authorised person. I understand that my child will only be allowed to leave the centre with an authorised person over the age of 16.
2. All children must be collected from Extend ED by 6pm. A late fee will apply if children are collected after 6pm.
3. Any child suffering from an illness which may in any way be transferred to other children or staff shall not be accepted into Extend-ED. Once such illness is diagnosed the parent/guardian shall be contacted and requested to resume

responsibility for that child. Exclusion periods are determined by The Department of Health booklet Communicable Disease-Guidelines for Teachers, Local Authorities and Child Care Centre's. The child/children will be accepted back into the centre upon provision of a clearance certificate from a medical practitioner. *Parents/Guardians are expected to inform staff if their child/children has been diagnosed with a communicable disease.*

4. Any changes of my child's enrolment form must be made known and recorded with the Early Learning Coordinator at the time of the change.
5. I understand that I or other person named in my child/children's record will be required to authorise the taking of my child/children outside the education centre for each outing within the 12 month period.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONDITIONS AND AGREE TO ABIDE BY THEM

NAME: _____ **SIGNED:** _____ **DATE:** _____