Enrolment Form

> *A Guardian includes parent of the child and/or a person with parental responsibilities for the child under a decision or court order. Parental responsibility is a term defined under section 61C of the Family Law Act 1975, which means all the duties, powers, responsibilities and authority which, by law, parents have in relation to children.*

Parents/Guardian Information 1	
First Name:	Middle Name:
Last Name:	Known as (Preferred Name):
Date of Birth: / /	Relationship to Child:
CRN:	
Is this a primary guardian ?	☐ Yes ☐ No

Contact Details		
Email Address:	Mobile Number:	
Home Number:	Work Number:	
Address:		
Suburb:	State:	Postcode:

Cultural Details	
Aboriginal or Torres Strait Islander Background:	Nationality:
Cultural Background:	Languages Spoken:
Religion:	

Education and Occupation Details	
Are you currently self employed studying or working?	☐ Yes ☐ No
Job Title/Occupation:	

Authorisation

This guardian is authorised to:

- ☐ authorise the service to seek medical treatment from a registered medical practitioner hospital or ambulance service, including transportation of the child(ren) by an ambulance service
- ☐ authorise the service to administer medication to the child(ren).
- ☐ authorise the service to take the child(ren) outside the service on excursions or outings, with the service's educators.
- ☐ be contacted in an emergency concerning the child(ren).
- ☐ drop off/pick up the child(ren) to/from the service.
- ☐ access information of the child(ren) via Xap Guardian Portal or Xap Smile App

A Guardian includes parent of the child and/or a person with parental responsibilities for the child under a decision or court order. Parental responsibility is a term defined under section 61C of the Family Law Act 1975, which means all the duties, powers, responsibilities and authority which, by law, parents have in relation to children.

Parents/Guardian Information 2	
First Name:	Middle Name:
Last Name:	Known as (Preferred Name):
Date of Birth: / /	Relationship to Child:
CRN:	
Is this a primary guardian ? ☐ Yes ☐ No	

Contact Details		
Email Address:	Mobile Number:	
Home Number:	Work Number:	
Address:		
Suburb:	State:	Postcode:

Cultural Details	
Aboriginal or Torres Strait Islander Background:	Nationality:
Cultural Background:	Languages Spoken:
Religion:	

Education and Occupation Details
Are you currently self employed studying or working? ☐ Yes ☐ No
Job Title/Occupation:

Authorisation
This guardian is authorised to:
☐ authorise the service to seek medical treatment from a registered medical practitioner hospital or ambulance service, including transportation of the child(ren) by an ambulance service
☐ authorise the service to administer medication to the child(ren).
☐ authorise the service to take the child(ren) outside the service on excursions or outings, with the service's educators.
☐ be contacted in an emergency concerning the child(ren).
☐ drop off/pick up the child(ren) to/from the service.
☐ access information of the child(ren) via Xap Guardian Portal or Xap Smile App

> *In case of an emergency, service staff will contact guardians initially. If contact is unsuccessful, the nominees will be contacted as per the authorisations and the contact priority set for them. An authorised nominee is defined under section 170 of national laws as a person who is authorised by guardians to collect the child from service.*

Nominee Information 1		
First Name:	Middle Name:	
Last Name:	Relationship to child:	
Email:	Mobile Number:	
Address:		
Suburb:	State:	Postcode:

Authorisation
This person is authorised to:
☐ authorise the service to seek medical treatment from a registered medical practitioner hospital or ambulance service, including transportation of the child(ren) by an ambulance service
☐ authorise the service to administer medication to the child(ren).
☐ authorise the service to take the child(ren) outside the service on excursions or outings, with the service's educators.
☐ be contacted in an emergency concerning the child(ren).
☐ drop off/pick up the child(ren) to/from the service.
☐ authorise my child to be transported by the service or on transportation arranged by the service

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Nominee Information 2		
First Name:	Middle Name:	
Last Name:	Relationship to child:	
Email:	Mobile Number:	
Address:		
Suburb:	State:	Postcode:

Authorisation
This person is authorised to:
☐ authorise the service to seek medical treatment from a registered medical practitioner hospital or ambulance service, including transportation of the child(ren) by an ambulance service
☐ authorise the service to administer medication to the child(ren).
☐ authorise the service to take the child(ren) outside the service on excursions or outings, with the service's educators.
☐ be contacted in an emergency concerning the child(ren).
☐ drop off/pick up the child(ren) to/from the service.
☐ authorise my child to be transported by the service or on transportation arranged by the service

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Nominee Information 3		
First Name:	Middle Name:	
Last Name:	Relationship to child:	
Email:	Mobile Number:	
Address:		
Suburb:	State:	Postcode:

Authorisation
This person is authorised to:
☐ authorise the service to seek medical treatment from a registered medical practitioner hospital or ambulance service, including transportation of the child(ren) by an ambulance service
☐ authorise the service to administer medication to the child(ren).
☐ authorise the service to take the child(ren) outside the service on excursions or outings, with the service's educators.
☐ be contacted in an emergency concerning the child(ren).
☐ drop off/pick up the child(ren) to/from the service.
☐ authorise my child to be transported by the service or on transportation arranged by the service

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Nominee Information 4		
First Name:	Middle Name:	
Last Name:	Relationship to child:	
Email:	Mobile Number:	
Address:		
Suburb:	State:	Postcode:

Authorisation
This person is authorised to:
☐ authorise the service to seek medical treatment from a registered medical practitioner hospital or ambulance service, including transportation of the child(ren) by an ambulance service
☐ authorise the service to administer medication to the child(ren).
☐ authorise the service to take the child(ren) outside the service on excursions or outings, with the service's educators.
☐ be contacted in an emergency concerning the child(ren).
☐ drop off/pick up the child(ren) to/from the service.
☐ authorise my child to be transported by the service or on transportation arranged by the service

Child Information		
First Name:		Middle Name:
Last Name:		Known as (Preferred Name):
Date of Birth: / /		Gender:
CRN:		Resides With:
Address:		
Suburb:	State:	Postcode:
List all the child's favourite activities and interests:		
Cultural Background of Child		
Aboriginal or Torres Strait Islander Background:		Country Of Birth:
Nationality:		Cultural Background:
Language Spoken:		Religion:
School Details		
Is the child currently attending school? ☐ Yes ☐ No		
Year Level:		
Child's Doctor and Insurance Information		
Medical Clinic Name:		
Doctor's Name:		
Clinic/Doctor's Contact No.:		
Medical Clinic Address:		
Suburb:	State:	Postcode:
Child's Medicare Number:		Medicare Expiry Date: / /
Ambulance Subscription No:		Subscription Expiry Date: / /
Private Health Insurance:		Insurance Membership No:
Child's Health and Immunisation Information		
Has your child been immunised? ☐ Yes ☐ No		
Immunisation Record:		

	Age	**Disease**
☐	Birth	Hepatitis B
☐	Two months (from six weeks)	Diphtheria, tetanus, pertussis, hepatitis B, polio, Haemophilus Influenzae type b (Hib)
		Pneumococcal
		Rotavirus

☐	Four months	Diphtheria, tetanus, pertussis, hepatitis B, polio, Haemophilus Influenzae type b (Hib)
		Pneumococcal
		Rotavirus
☐	Six months	Diphtheria, tetanus, pertussis, hepatitis B, polio, Haemophilus Influenzae type b (Hib)
☐	12 months	Measles, mumps, rubella (MMR)
		Meningococcal ACWY
		Pneumococcal
☐	18 months	Measles, mumps, rubella, varicella (chickenpox) (MMRV)
		Diphtheria, tetanus, pertussis
		Haemophilus Influenzae type b (Hib)
☐	Four years	Diphtheria, tetanus, pertussis (whooping cough), polio
☐	Six months of age to less than five years of age (from may 2018)	Influenza

Supporting Document type:	
Please attach the photo copy of following documents type with this application. (if applicable) Copy of the supporting document	
Please attach the photo copy of following documents type with this application. (if applicable) Copy of medical exemption from registered medical practitioner	
Has the child been diagnosed with any of the following health conditions?:	
Anaphylaxis ☐ Yes ☐ No	
Does an Anaphylaxis management plan, signed by a doctor, exist for the child? ☐ Yes ☐ No	
Please attach the photo copy of following documents type with this application. (if applicable) Copy of anaphylaxis management plan	
Exp. Date of management plan: / /	
Has an Anaphylaxis Risk minimisation and communication plan been completed in consultation with the service/educator? ☐ Yes ☐ No	
Please attach the photo copy of following documents type with this application. (if applicable) If Yes, please upload a copy of the plan below	
EpiPen/Anapen Expiry Date: / /	Anaphylaxis Triggers:
Medication Name:	Expiry Date of Medication:
Asthma ☐ Yes ☐ No	
Does an Asthma management plan, signed by a doctor, exist for the child? ☐ Yes ☐ No	
Please attach the photo copy of following documents type with this application. (if applicable) Copy of asthma management plan	
Exp. Date of management plan: / /	

Has an Asthma Risk minimisation and communication plan been completed in consultation with the service/educator? ☐ Yes ☐ No	
Please attach the photo copy of following documents type with this application. (if applicable) 📎 If Yes, please upload a copy of the plan below	
Asthma Triggers:	
Asthma Medication *Ventolin or another asthma treatment must be provided to the centre. This medication must remain at the centre at all times in a clearly labelled plastic bag.*	
Medication Name:	Expiry Date of Medication:
Allergy ☐ Yes ☐ No	
Does an Allergy management plan, signed by a doctor, exist for the child? ☐ Yes ☐ No	
Please attach the photo copy of following documents type with this application. (if applicable) 📎 Copy of allergy management plan	
Expiry Date of Plan: / /	
Has an Allergy Risk minimisation and communication plan been completed in consultation with the service/educator? ☐ Yes ☐ No	
Please attach the photo copy of following documents type with this application. (if applicable) 📎 If Yes, please upload a copy of the plan below	
Allergy Medication *Medication must be provided to the centre. This medication must remain at the centre at all times in a clearly labelled plastic bag.*	
Allergy Triggers:	
Medication Name:	Expiry Date of Medication:
Diabetes ☐ Yes ☐ No	
Does a Diabetes management plan, signed by a doctor, exist for the child? ☐ Yes ☐ No	
Please attach the photo copy of following documents type with this application. (if applicable) 📎 Copy of diabetes management plan	
Expiry Date of Plan: / /	
Has a Diabetes Risk minimisation and communication plan been completed in consultation with the service/educator? ☐ Yes ☐ No	
Please attach the photo copy of following documents type with this application. (if applicable) 📎 If Yes, please upload a copy of the plan below	
Diabetes Medication	
Medication Name:	Expiry Date of Medication:
Will the child require medication (other than indicated above) whilst attending the service? ☐ Yes ☐ No	
Other Medication	
Medication Name:	Expiry Date of Medication:
Does the child have any dietary requirements ☐ Yes ☐ No	
If yes, please specify the dietary restrictions:	

Please attach the photo copy of following documents type with this application. (if applicable)
Supporting Document

Does the child have a diagnosed disability? ☐ Yes ☐ No

If yes, please specify the diagnosed disability:

Please attach the photo copy of following documents type with this application. (if applicable)
Copy of the supporting document

Is the child accessing any specialist services or on a waiting list for such services? ☐ Yes ☐ No

Specialist Service(s):

More Details on Specialist Services:

Please attach the photo copy of following documents type with this application. (if applicable)
Copy of the supporting document

Does the child have any other additional needs? ☐ Yes ☐ No

If yes, please specify the other additional needs:

Please attach the photo copy of following documents type with this application. (if applicable)
Copy of the supporting document

Is the child currently in an out of home care arrangement (including kinship care)? ☐ Yes ☐ No

If yes, please specify the out of home care arrangement:

Does the parent/guardian have any specific conditions that make it difficult to get the child to child care? (e.g. a disability or medical condition) ☐ Yes ☐ No

If yes, please specify the specific condition:

Please attach the photo copy of following documents type with this application. (if applicable)
Copy of the supporting document

Guardian Consent

Participation:

Does the parent/guardian give permission for the child to participate in cultural or religious celebrations or events? (such as Christmas and Easter) ☐ Yes ☐ No

If no, specify the celebrations or events:

Sunscreen Authorisation:

Authority for service staff to administer sunscreen:

◯ Parent/Guardian gives permission for service staff members to apply a suitable sunscreen to the child.

◯ Child is sensitive/allergic to some sunscreen brands. Parent/Guardian will provide a suitable sunscreen brand for the child and gives permission for service staff members to apply this sunscreen.

> *Sunscreen that is provided by you for your child must be placed in a sealed container clearly labelled with your child's name.*

Preferred sunscreen brand:

Photographs and Publicity:

Does the parent/guardian give permission for the child's name and photographs to be used in the service (service display's)? ☐ Yes ☐ No

Does the parent/guardian give permission for the child's name and photographs to be used for the service's promotional events including media? ☐ Yes ☐ No
Does the parent/guardian give permission for the child's name and photographs to be included in group posts that are distributed to the service's other guardians? ☐ Yes ☐ No

Court Appointed Orders	
Are there any court/parenting/intervention orders or parenting plans relating to this child? ☐ Yes ☐ No	
Summary of the court/parenting/intervention order or parenting plan:	
Please attach the photo copy of following documents type with this application. (if applicable) Copy of the court/parenting/intervention or parenting plan	
Expiry Date of Order/Plan: / /	Person to whom the order relates:
Authorised Contact for this early years enrolment:	

Declaration
As the person with lawful authority for the child or children referred to on this enrolment form:
I _____, declare that the information in this enrolment form is true and correct and immediately inform the child care centre in the event of any change to this information.I also make the following declarations:
☐ I agree that all the information I have provided in this enrolment form is true and correct.
☐ I am a person with lawful authority over the child(ren) referred to in this application.
☐ I agree to collect or make an arrangement for the collection of the child referred to in this enrolment form if the child becomes unwell at the service.
☐ I allow service staff or management to seek and authorise any medical treatment from a medical practitioner and/or arrange ambulance transportation for the child to a hospital in case of emergency. I also take liability for all expenses that may arise.
☐ I agree to inform the service of all medical needs and requirements of my child. This includes relevant documentation, medication and authorisation to follow the medical plan/administer medication.
☐ I agree that the ongoing management of the child's medical condition, if any, remains my sole responsibility and is not, and in no circumstances becomes, the obligation of the service staff or management.
☐ I agree that in the event of any adverse reaction by the child to the administration of medication which I have authorised or in the event that any action or inaction on the part of the service staff or management results in any aggravation, exacerbation, acceleration or deterioration of any medical condition suffered by the child, I release the service, its staff, management and other relevant personnel and their respective assignees and insurers from all actions, suits and claims of any nature, I or my child may have relating to the administration of medication or the failure to administer or any action or failure to act related to any medication condition identified in the child's action/management plan.
☐ I agree to inform the service if my child contracts any illness which could be detrimental to the health of others at the service.
☐ I accept full responsibility for my child's belongings when they are attending the service.
☐ I understand that if my child continuously demonstrates inappropriate behaviour, I may be called to collect them. In the case of serious inappropriate behaviour after appropriate behaviour guidance procedures have been followed, I will be notified and my child may be removed or suspended for a period of time or excluded permanently from the service.
☐ I acknowledge that there may be a time when my child's full name will be displayed at the service. If I have any concerns about this, I will advise in writing.
☐ I agree to pay all fees as communicated by service.
☐ In the event of overdue fees, I agree that my account may be suspended until full payment is made in accordance with the relevant policies. I understand that I am responsible for any cost involved with the recovery of debt and any further action required.
☐ I agree to the Terms and Conditions and Privacy Policy of the service.
☐ I agree to the Terms & Conditions and Privacy Policy of Xap Technologies Pty Ltd.
☐ The service reserves the right to change terms and conditions at any time.

Days/Program	
CentreName:	
BookingType: ☐ Permanent ☐ Casual	*(Please complete the program details, if you are requesng permanent care for the child.)*
Program 1	
Program Name (Please select only one from the available programs)	
Booking Start Date(dd/mm/yyyy):	Booking End Date(dd/mm/yyyy):
Preffered Days (Please select from the available days in the program): ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	
☐ I am flexible with days ☐ I can accept less days	
Program 2	
Program Name (Please select only one from the available programs)	
Booking Start Date(dd/mm/yyyy):	Booking End Date(dd/mm/yyyy):
Preffered Days (Please select from the available days in the program): ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	
☐ I am flexible with days ☐ I can accept less days	

Office/Educator Use Only		
Has a communication plan been developed to ensure staff and volunteers are informed about:		
The medical conditions policy	☐ Yes	☐ No
The medical management plan	☐ Yes	☐ No
The risk minimisation plan for the child	☐ Yes	☐ No
Has the child's parent/guardian endorsed the medical management plan and risk minimisation plan for the child?	☐ Yes	☐ No
Educator Responsible:	Date Implemented: / /	

Child's Health Documents (if applicable)		
Has your child been immunised?		
Copy of Immunisation History Statement	☐ Yes	☐ No
Copy of Immunisation Status Certificate	☐ Yes	☐ No
Copy of medical exemption from registered medical practitioner	☐ Yes	☐ No

Does your child suffer from any of the following health conditions? (if applicable)		
Anaphylaxis		
Copy of anaphylaxis management plan	☐ Yes	☐ No
If Yes, please upload a copy of the plan below	☐ Yes	☐ No
Asthma		
Copy of asthma management plan	☐ Yes	☐ No
Allergy		
Copy of allergy management plan	☐ Yes	☐ No
Diabetes		
Copy of diabetes management plan	☐ Yes	☐ No
Dietary Restrictions		
Supporting Document	☐ Yes	☐ No
Diagnosed or Disability		
Copy of the supporting document	☐ Yes	☐ No
Specialist Services		
Copy of the supporting document	☐ Yes	☐ No
Additional Needs		
Copy of the supporting document	☐ Yes	☐ No
Out of Home Care Arrangement		
Copy of the supporting document	☐ Yes	☐ No