Deposit taken Y/N Please attached receipt here

Child's Full Name:

MINILAND EARLY LEARNING CENTRE

CENTRE ENROLMENT FORM

Welcome to Miniland Early Learning Centre

Hours of operation: 7 am to 6 pm, 50 weeks of the year

Miniland Early Learning Centre is a leading childcare centre providing the high quality care for children aged 6 months to 6 years.

Is your child immunised? ☐ If yes please tick. We are required by law not to accept children that are not immunised. You must attach An Australian Childhood Immunisation Register (ACIR) Immunisation History Statement which shows that your child s up to date with their scheduled immunisation. An Official Objection can be accepted. If your child s from overseas their immunisation certificate needs t be translated.

OFFICE USE ONLY	
Attendance day offered (please circle days)	M T W T F Room_____
Offer date __/___/___	Staff member
Offer subject to availability at the time of the enrolment form being returned	

ADD:

- Miniland ELC Agreement at the end
- Direct Debit form
- Payment schedule

Miniland ELC requires this form to be completed and all documentation attached prior to your child's first day of childcare with us. This information must be completed by one of the child's parents, who have lawful authority in relation to the child.

Please notify us of any change of details, as soon as they arise.

What room your child will be placed in:

Babies Toddlers Pre - school

Please CIRCLE the preferred days that your child will require care:

Monday Tuesday Wednesday Thursday Friday

Start Date: _____

PARENT/GUARDIAN DETAILS

PRIMARY PARENT

Title: _____ First Name(s): _____Middle Name:_____

Surname:_____

CRN: ***Parent 1 is claiming CCB from Centrelink & child will come under Parent 1 CRN. Please note Parent and child have their own individual CRN number.***

Date of Birth: _____ Country of Birth: _____

Gender: _____

Home Phone: _____ Work Phone:_____

Fax:_____ Mobile:

Email:

Street Address

Address 1

Address 2

Suburb: State: Postcode:

Country:

Postal Address Same as Above ☐

Attention To:

Address 1

Address 2

Suburb: **State:** **Postcode:**

Country:

MEDICAL INFORMATION

Family Doctor:

Address:

Suburb: **State:** **Postcode:**

Doctor Phone:

Medicare Number:

Ambulance Cover: **YES** / **NO** **Ambulance Number:**

Health Insurance Fund: **YES** / **NO** **Insurance Number:**

Health Insurance Name

Additional Comments:

GENERAL INFORMATION

Primary Parent Occupation:

Country of Birth:

Cultural background:

Religion:

Hobbies:

First Language: **Second Language:**

PARTNER DETAILS

Title: **First Name(s):** **Middle Name:**

Surname:

Date of Birth: **Country of Birth:**

Gender:

Home Phone: **Work Phone:**

Fax: **Mobile:**

Email:

Street Address

Same as Primary Parent ☐

Address 1

Address 2

Suburb: **State:** **Postcode:**

Country:

Additional Comments:

COURT/CUSTODIAL ORDERS

Are there any court orders, parenting orders or parenting plans relating to the powers, duties and responsibilities or authorities of any person in relation to the child or access to the child?

YES NO

Are there any other court orders relating to the child's residence or the child's contact with a parent or other person?

YES NO

Please attach a copy of all relevant documentation. Without copies of current court orders or documentation, staff and carers cannot enforce parents' requests.

EMERGENCY/ AUTHORISED PERSON CONTACTS

In case of an emergency, we will contact the parents/guardian initially. If contact is unsuccessful, we will contact the following people, in the order that they are listed.

Please Note: Photo ID must be presented on pick up.

CONTACT ONE

Full Name:

Phone 1: Phone 2:

Mobile:

Relationship to Child:

Authorised for Pick up: YES / NO

Address 1:

Address 2:

Suburb: State: Postcode:

Country:

CONTACT TWO:

Full Name:

Phone 1: Phone 2:

Mobile:

Relationship to Child:

Authorised for Pick up: YES / NO

Address 1:

Address 2:

Suburb: State: Postcode:

Country:

CONTACT THREE:

Full Name:

Phone 1: Phone 2:

Mobile:

Relationship to Child:

Authorised for Pick up: YES / NO

Address 1:

Address 2:

Suburb: State: Postcode:

Country:

CHILD DETAILS:

First Name(s): **Middle Name:**

Surname:

Preferred Name:

Child CRN:

Please note Parent and child have their own individual CRN number

Date of Birth:

Gender: ☐ **Female** ☐ **Male**

Home Address:

Suburb: **Post Code:**

Please provide the name and ages of your child's siblings:

Name: Age:

Name: Age:

Name: Age:

Please provide the name and ages of any other close relations attending the same centre:

Name: Age:

Name: Age:

Name: Age:

Has your child been toilet trained? YES / NO

Please provide details, if necessary:

General Routine:

Does your child sleep in a bed or a cot?

Please describe your child's sleeping times/habits (including day/night, comforters, and fears/phobias):

DIETARY REQUIREMENTS

Does your child have any special dietary or cultural restrictions or particular food dislikes or likes?

If yes, please provide relevant details below:

Please list any other details that could help us in providing your child with the most suitable dietary options:

Any known Allergies: YES / NO

If yes, please provide details below:

Medications:

Relevant Doctor Name:

Doctor Phone:

CHILD MEDICAL/ IMMUNISATION INFORMATION

Family Doctor Name:

Doctor Phone:

Medical Conditions:

Medications:

Immunisation Record

Please attach a copy of all relevant documentation in regards to the following.

Is your child fully immunised? YES / NO

Immunisation Schedule

Birth	Yes / No/ Exempt	2 Months	Yes / No/ Exempt
4 Months	Yes / No/ Exempt	6 Months	Yes / No/ Exempt
12 Months	Yes / No/ Exempt	18 Months	Yes / No/ Exempt
4 Years	Yes / No/ Exempt		

Please ensure you notify us the completion of each immunisation update.

Has your child ever been diagnosed with any of the following?

German Measles	YES / NO
Seizures	YES / NO
Mumps	YES / NO
Convulsions	YES / NO
Whooping Cough	YES / NO
Chicken Pox	YES / NO
Measles	YES / NO

Other (please specify)

If you have ticked YES to any in the list above, please specify relevant details below:

Does your child have a diagnosed disability or special needs? YES / NO

If yes, please provide relevant details below:

Does your child take prescribed medication or treatment on a regular basis? YES / NO

If yes, please provide relevant details below:

Does your child suffer from anaphylaxis? YES / NO

If yes, please provide relevant details below:

CHILD GENERAL INFORMATION

Country of Birth:

Ethnicity:

Religion:

First Language Second Language:

Hobbies:

Skills:

AUTHORISATION AND AGREEMENT

PLEASE READ THE FOLLOWING AGREEMENT CAREFULLY BEFORE SIGNING. PLEASE ASK IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU ARE UNSURE OF.

Please tick the following

In the event of an emergency, illness or accident concerning my child, and the centre being unable to contact me or the other persons authorised by me, I consent to the centre actioning on my behalf, medical, dental, hospital or transportation by ambulance needed for my child. I accept liability for medical, dental, hospital or ambulance attention as required for my child.	**Signature:**	**Date:**
Have SPF30+ sunscreen applied prior to sun exposure (If not, please provide a letter releasing the centre of any Liability)	**Signature:**	**Date:**
I give permission for my child to be photographed whilst at the Centre, for the purpose of developmental documentation. I understand that photographs will not be released to outside agencies, or be used for promotional purpose without my written authority.	**Signature:**	**Date:**
If my child is **NOT** immunised, I agree to withdraw them from this centre if there is an outbreak of a notifiable infectious disease as outlined in the Public Health Amendment Act 1992 for the duration of the outbreak and fees will still be paid.	**Signature:**	**Date:**
I understand that fees must be paid once invoiced within the stated due date and that my child's place at the Centre may be terminated if fees are not up to date.	**Signature:**	**Date:**
I hereby give consent to members of centre staff guiding my child around the perimeter of the Pre-School as may be required or necessary within the policy set down by the Regulations	**Signature:**	**Date:**
I have been informed that **ALL NUTS and NUT-BASED FOODS HAVE BEEN BANNED** from Miniland ELC due to some children who are Anaphylactic. I understand if my child has any foods containing a nut, that I will be fully responsible for the consequences.	**Signature:**	**Date:**
I hereby acknowledge that I have received and read the		

General Information Sheet and the Terms and Conditions regarding Miniland ELC and agree to abide by the Information and Policies as stated therein.	**Signature:**	**Date:**
I give permission for Centre Staff to carry out or seek urgent medical, dental or hospital treatment or transportation of the child by an ambulance service.	**Signature:**	**Date:**
I hereby give permission for Miniland ELC to administer paracetamol to my child in accordance with the Medication Policy of Miniland ELC .	**Signature:**	**Date:**

TERMS AND CONDITIONS:

I/We have read, understood and agree to abide by the conditions of this contract.

Primary Parent

Print Name_____

Signature_____

Date _____

Miniland ELC Centre Coordinator

Print Name_____

Signature_____

Date _____

How did you find out about Miniland ELC ?

Word of mouth ☐ **Facebook** ☐ **Advertising** ☐

Internet search ☐ **Website** ☐ **Other (please Specify)** ☐