scola
early learning

371 MARMION STREET
MELVILLE WA 6156
M 0432 107 929

WWW.SCOLAEARLYLEARNING.COM

Child Enrolment

CHILD'S INFORMATION:						
GIVEN NAMES:			LAST NAME:			
ANY OTHER NAMES BY WHICH THE CHILD IS KNOWN AND ANY FORMER NAMES OF THE CHILD:						
ADDRESS (IF DIFFERENT TO PARENT 1):						
DATE OF BIRTH:	PLACE OF BIRTH:			SEX:	○ MALE	○ FEMALE
INTENDED START DATE:			LANGUAGE SPOKEN:			
ETHNICITY:			RELIGION:			
INDIGENOUS OR TORREST STRAIT ISLANDER:					○ YES	
CRN:						

DAYS/TIMES REQ'D:	MON	TUE	WED	THU	FRI
ARRIVAL TIME:					
DEPARTURE TIME:					

IS THIS CHILD ATTENDING ANOTHER CENTRE IN THE SAME WEEK?

PLEASE ADVISE NUMBER OF HOURS AT OTHER CENTRE:

IF YES, DO YOU WISH TO CLAIM MAXIMUM CCB HOURS AT SCOLA IF YOUR CHILD EXCEEDS THEIR CCB LIMIT?

GENERAL NEEDS:
DOES YOUR CHILD PARTICIPATE IN FESTIVALS/CELEBRATIONS? YES / NO
IF YES, PLEASE PROVIDE INFORMATION CONCERNING THE CHILD'S RELIGION AND CULTURAL BACKGROUND AND ANY PRACTICE THAT IS TO BE OBSERVED AT THE SERVICE IN RESPECT OF THE CHILD BECAUSE OF THAT RELIGION OR BACKGROUND.
ARE THERE ANY WORDS WE NEED TO KNOW IN ANY LANGUAGE TO HELP MAKE YOUR CHILD'S DAY SMOOTHER?
DOES YOUR CHILD HAVE ANY SPECIAL COMFORTER OR FEARS (E.G MOWERS...)?
ANY OTHER SPECIFIC NEEDS:

SIGNED:	DATED:
SIGNED:	DATED:

(OFFICE USE ONLY):		
DATE:	SIGNED:	WITNESS:

BIRTH CERTIFICATE SIGHTED (OFFICE USE): ○ PLEASE TICK

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Child Medication Form

MEDICAL DETAILS:	
DOCTOR:	DENTIST:
ADDRESS:	ADDRESS:
PHONE:	PHONE:
MEDICARE NUMBER:	MEDICARE NUMBER:
HEALTH CARE FUND NO:	HEALTH CARE FUND NO:

I HEREBY GIVE MY WRITTEN CONSENT TO THE CARRYING OUT OF APPROPRIATE MEDICAL, DENTAL, AMBULANCE OR HOSPITAL TREATMENT, IN THE EVENT THAT SUCH ACTION APPEARS TO BE NECESSARY BECAUSE THE CHILD HAS BEEN INJURED, OR IS ILL, AT THE PREMISES.
NOTE: NOTHING IN THIS CLAUSE LIMITS THE AUTHORITY OF A MEDICAL PRACTITIONER OR DENTIST TO CARRY OUT EMERGENCY MEDICAL OR DENTAL TREATMENT ON A CHILD WITHOUT THE CONSENT OF THE CHILD'S PARENT AS REFERRED TO IN SECTION 174 OF THE ACT.

SIGNED BY THE PARENT:	DATED:

MEDICAL HEALTH PLANS (INCLUDING ANAPHYLAXIS, ASTHMA, DIABETES, AND EPILEPSY):

HAVE YOU BEEN PROVIDED A RISK MANAGEMENT PLAN FOR A HEALTH CONCERN:

IF YES, PLEASE PROVIDE INFORMATION REGARDING THIS PLAN. MANAGEMENT WILL ORGANISE A TIME TO DISCUSS THE RISK MANAGEMENT PLAN FOR SCOLA EARLY LEARNING AND YOUR INCLUSION WILL BE NECESSARY:

DOES YOUR CHILD HAVE ANY DIETARY GUIDELINES OR RESTRICTIONS? PLEASE PROVIDE DETAILS HERE AND MANAGEMENT WILL ORGANISE A TIME TO COLLECT INFORMATION FOR PREVENTING ANY HARM IN THE CENTRE:

HEALTH STATUS:

HAS YOUR CHILD BEEN IMMUNISED (PLEASE PROVIDE EVIDENCE, E.G., BLUE BOOK):	○ PLEASE TICK
DOES YOUR CHILD: (PLEASE PROVIDE DETAILS)	
• HAVE ALLERGIC REACTIONS E.G. FOOD, MEDICINE, GRASS, BEES, FACE PAINT ETC.?	○
• HAVE ANY BEHAVIOUR DIFFICULTIES WE SHOULD KNOW ABOUT?	○
• HAVE A KNOWN CASE OR RISK OF ANAPHYLAXIS AND A MANAGEMENT PLAN?	○
• REGULARLY VISIT A SPECIALIST?	○
• HAVE ANY SPECIAL MEDICAL CONDITION?	○
• TAKE ANY REGULAR MEDICATION?	○

HISTORY:

HAS YOUR CHILD EVER CONTRACTED ANY OF THE FOLLOWING?	○ PLEASE TICK
• GERMAN MEASLES	○
• MUMPS	○
• WHOOPING COUGH	○
• MEASLES	○
• SEIZURES OR CONVULSIONS	○
• CHICKEN POX	○

(OFFICE USE ONLY):

DATE:	SIGNED:	WITNESS: