2/90 Tamar St Ballina NSW 2478 Ph: 6686 7799
www.fdcfarnorthcoast.com.au After Hrs: 0429 932 485
admin@fdcfarnorthcoast.com.au ABN: 85 676 459 681

# ENROLMENT FORM

Your completed enrolment form will be required at the time of interview.
This information will be provided to your child's educator and treated as highly confidential.
**Please return completed enrolment form to 2/90 Tamar St, Ballina NSW 2478 or email to enrol@fdcballinabyron.com.au**
**All sections must be completed. If any sections are not applicable, please write N/A.**

## *1. Information about the child 1:*

| | | |
|---|---|---|
| Child's Customer Reference Number (CRN): (Obtained from the DHS) | | |
| First Name: | Middle Name: | |
| Surname: | | |
| Preferred Name: | | |
| Date of Birth: / / | Gender: ☐ Female ☐ Male | |
| Medicare Number: _ _ _ _ _ _ _ _ _ _ Number beside your child's name on care _ | | |
| Child's Address: Post Code: | | |
| Does your child attend pre-school/school/other service (e.g. Long Day Care): ☐ No ☐ Yes<br>If yes, please indicate name of school / other service: | | |
| Is your child related to the Educator? ☐ No ☐ Yes | what is the relationship? | |
| Country of Birth: | | |
| Language(s) spoken at home: | | |
| Is your child of Aboriginal or Torres Strait Islander origin (please tick):<br>☐No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal & Torres Strait Islander | | |
| Religion (if applicable): Please provide any info (if any) concerning child's religion and cultural background? | | |

| | | |
|---|---|---|
| Does the child have any special needs (please tick):<br>☐ No ☐ Yes | If Yes please tick all applicable:<br>Self-Care: ☐ No ☐ Yes<br>Social interactions & relationships: ☐ No ☐ Yes<br>Communication: ☐ No ☐ Yes<br>Mobility ☐ No ☐ Yes | Other: |

| | | |
|---|---|---|
| Is the child from (please tick): A culturally & linguistically diverse background | ☐ No | ☐ Yes |
| A refugee background who have been subjected to trauma: | ☐ No | ☐ Yes |
| The child's place has been sought by a state or territory child protection worker: | ☐ No | ☐ Yes |
| The child is in care of the state, or other forms of out of home care: | ☐ No | ☐ Yes |

If yes, please explain:

**Immunisation:** All parents claiming Child Care Benefit for children must provide proof of immunisation to the DHS (Department of Human Services), or register as a conscientious objector. Please note that confirmation of immunisation needs to be given to the Family Day Care office upon enrolment and each time immunisation is updated. Is your child immunised (please tick): ☐ No ☐ Yes ☐ Partially

| | |
|---|---|
| Does your child have any allergies or sensitivities including asthma and/or anaphylaxis? | ☐ No ☐ Yes If yes, please attach a medical action plan supplied by a doctor |
| Does your child have any medical conditions? (e.g. epilepsy, diabetes, deafness, heart murmur etc) | ☐ No ☐ Yes If yes, please attach the child's management procedure to be followed |
| Does your child have any additional needs or disability? (e.g. cerebral palsy, autism, ADHD etc) | ☐ No ☐ Yes If yes, please provide details and/or medical reports. |
| Does your child have any dietary restrictions, sensitivities or mild allergies? Skin, hay fever etc | ☐ No ☐ Yes If yes, please provide a list of the restrictions in writing. |

***2. Information about the child's parents/guardians:***

| **Parent / Guardian 1 – person claiming CCS** | |
|---|---|
| Customer Reference Number (CRN): (Obtained from the DHS) | |
| First Name: | Middle Name: |
| Surname: | Date of Birth: / / |
| Preferred Name: | |
| Relationship to the child: | Gender: ☐ Female ☐ Male |
| Does the child live with you? ☐ Yes ☐ No ☐ Shared Care | |
| Home Address:<br>Post Code: | |
| Postal Address (if different from home address): | |
| Phone: Home: | Mobile: |
| Email address: | |
| Work / Study: ☐ Full Time ☐ Part Time ☐ Casual ☐ Self Employed ☐ Student ☐ Home Duties | |
| Employer / Place of Study (if applicable). Name: | |
| Occupation: | |
| Work Phone Number: | |
| Country of Birth: | |
| Language(s) spoken at home: | |
| Ethnic Group (please tick):<br>☐ Aboriginal ☐ Torres Strait Islander ☐ English Speaking ☐ Non English Speaking | |

***3. Information about the child's parents/guardians:***

| **Parent / Guardian 2.** | |
|---|---|
| First Name: | Middle Name: |
| Surname: | Date of Birth: / / |
| Preferred Name: | |
| Relationship to the child: | Gender: ☐ Female ☐ Male |
| Does the child live with you? ☐ Yes ☐ No ☐ Shared Care | |
| Home Address:<br>Post Code: | |
| Postal Address (if different from home address): | |
| Phone: Home: | Mobile: |
| Email address: | |
| Work / Study: ☐ Full Time ☐ Part Time ☐ Casual ☐ Self Employed ☐ Student ☐ Home Duties | |
| Employer / Place of Study (if applicable). Name: | |
| Occupation: | |
| Work Phone Number: | |
| Country of Birth: | |
| Language(s) spoken at home: | |
| Ethnic Group (please tick):<br>☐ Aboriginal ☐ Torres Strait Islander ☐ English Speaking ☐ Non English Speaking | |

**Court Order / Parenting Order or Plan** (contact, residence, AVO etc). ☐ No ☐ Yes If yes, please explain:
Please attach a copy of any orders relating to the child.

**Access Authorisation:** I give authority for the child referred to in this confidential record nominate the following person/s as contacts as follows: **Please make sure each Access Authorised person has their own personal email address so that they can receive a pin to sign child/ren in & out of care.**
**NOTE: All Access Authorised People must be 18 years and older**

| | | |
|---|---|---|
| **Contact 1:** Full Name: | | Gender: ☐ Male ☐ Female |
| Address: | | Post Code: |
| Home Phone: | Mobile: | Work Phone: |
| Email address: | | |
| Relationship to child: | | |

Please tick the box/es below to confirm the level of authorisation you give to this person:

- ☐ Do you authorise this person to drop off and collect your child/ren on your behalf?
- ☐ Do you authorise this person to consent to medical treatment and/or authorise administration of medication to your child on your behalf?
- ☐ Do you authorise this person to be contacted in the event of an emergency if you cannot be immediately contacted?
- ☐ Do you authorise this person to consent for your child/ren to be taken outside the education and care service premises with an educator?

| | | |
|---|---|---|
| **Contact 2:** Full Name: | | Gender: ☐ Male ☐ Female |
| Address: | | Post Code: |
| Home Phone: | Mobile: | Work Phone: |
| Email address: | | |
| Relationship to child: | | |

Please tick the box/es below to confirm the level of authorisation you give to this person:

- ☐ Do you authorise this person to drop off and collect your child/ren on your behalf?
- ☐ Do you authorise this person to consent to medical treatment and/or authorise administration of medication to your child on your behalf?
- ☐ Do you authorise this person to be contacted in the event of an emergency if you cannot be immediately contacted?
- ☐ Do you authorise this person to consent for your child/ren to be taken outside the education and care service premises with an educator?

| | | |
|---|---|---|
| **Contact 3:** Full Name: | | Gender: ☐ Male ☐ Female |
| Address: | | Post Code: |
| Home Phone: | Mobile: | Work Phone: |
| Email address: | | |
| Relationship to child: | | |

Please tick the box/es below to confirm the level of authorisation you give to this person:

- ☐ Do you authorise this person to drop off and collect your child/ren on your behalf?
- ☐ Do you authorise this person to consent to medical treatment and/or authorise administration of medication to your child on your behalf?
- ☐ Do you authorise this person to be contacted in the event of an emergency if you cannot be immediately contacted?
- ☐ Do you authorise this person to consent for your child/ren to be taken outside the education and care service premises with an educator?

| **HEALTH DETAILS:** | |
|---|---|
| **DOCTOR:**<br>Name: | Phone Number: |
| Address: | Post Code: |
| **DENTIST:**<br>Name: | Phone Number: |
| Address: | Post Code: |

**Photo Authorisation:**

Whilst your child is in BBFDC, photos may be taken.

Do you give permission for these photos to be used for:

| | | |
|---|---|---|
| Training Purpose | ☐ No | ☐ Yes |
| Promotional Use | ☐ No | ☐ Yes |
| Educators to document learning experiences, development for the albums | ☐ No | ☐ Yes |
| Email purposes | ☐ No | ☐ Yes |
| BBFDC Web site | ☐ No | ☐ Yes |

**I request to receive the Weekly parent statements via:** ☐ Email ☐ Post ☐ Not to receive

**PARENT'S AUTHORISATION:**

**1.** I accept the policies and procedures set down by BBFDC and agree to abide by these conditions, I understand that BBFDC policy manual is available for viewing at all times. I also understand that I will be provided with a parent booklet regarding Ballina Byron Family Day Care (BBFDC).

**2.** I agree in order to be eligible for Australian Government fee assistance (e.g. CCS), the care arrangement and all associated invoices, receipts and statements must make clear that the care is being provided by the service and that the fees are being paid to the service.

**3.** I agree to abide by the conditions outlined in the Educators Individual Fee Schedule and Parent/Educator Agreement regarding payment of fees, food provisions and other arrangements as contained therein.

**4.** I agree to notify the Family Day Care office (ph 6686 7799) of any changes in the agreed hours or days of care and to sign the relevant forms pertaining to this.

**5.** I agree to record and initial actual arrival and departure times on attendance records, as required by the Department of Education, Employment and Workplace Relations, as an accurate record of actual hours of attendance. I agree to sign the attendance record stating this is an accurate record of hours for which payment is to be made.

**6.** I am aware that *full fees* are to be paid if my Child Care Subsidy (CCS) is cancelled or waiting processing by the Department of Human Services (DHS).

**7.** I agree to keep receipts issued to me by the educator as a record of fees paid.

**8**. I authorise the Co-ordination Unit to deduct the amount of Parent Levy paid by myself to the educator.

**9.** I understand my child will be visited by a scheme Co-ordinator who will observe the developmental progress of my child at regular intervals and make referrals to other agencies if required with my consent.

**10.** I agree to supply immunisation records (ACIR statement) to the Family Day Care Office each time my child's immunisation is updated. Please be aware as per Parent Booklet as directed by Public Health Unit.

**11.** In case of accident or other emergency resulting in the need of immediate medical, hospital or dental treatment, if parent/guardian not contactable, I hereby give my consent for the educator to contact an

ambulance or arrange for my child to be seen by his/her doctor or failing that the nearest hospital, medical or dental service available. I authorise transportation of my child by an ambulance service and agree to pay all costs incurred.

**12.** I agree that in an emergency situation or drill where evacuation is necessary that my child may need to leave the service under the direction and supervision of the educator.

**13**. In case of my child contracting an infectious disease, I agree to exclude him/her from the family day care home for a period, recommended by the NSW Dept. of Health, and to pay the regular childcare costs as a holding fee for my child's placement.

**14**. I understand that parent permission notes are to be signed for each excursion outside the educator's home. Routine excursion forms can be signed for yearly, e.g. playgroup, library visits, park, school drop-offs and pick-ups. All families are to be informed prior to outings undertaken by the educator under all circumstances. I agree to pay all costs of excursions and outings to the educator in addition to regular fees if applicable.

**15**. I agree to provide accessible emergency contact details to my educator as an alternate option to the parent/guardian in case of an emergency and the parent/guardian cannot be contacted.

**16**. I understand that Family Day Care placements operate according to Department of Education, Employment and Workplace Relations Priority of Access Guidelines and that I may be asked to vacate my position for someone on a higher priority.

**17.** A parent enrolment fee of $60.00 is payable upon enrolling for care with the scheme. This fee is non-refundable. Payment can be made at the Ballina Office (2/90 Tamar Street, Ballina NSW 2478), or via post (P.O. Box 544, Ballina Byron Family Day Care NSW 2478) or direct debit payment to Westpac Bank (BSB No: 032 591, Account No: 360 599 – If choosing this option please quote your family surname as a reference).

Signed by (please print full name) ……

Signature: …… Date: …….

**'This information is being collected with the principles of the Privacy and Personal Information Protection Act 1998 and accordingly will only be used for the purpose of which it is being collected.'**

**ADDITIONAL INFORMATION:**

**OFFICE USE ONLY:**

| | |
|---|---|
| c.c: Educator (Name):<br><br>Copied By (initial): Date: | c.c: Educator (Name):<br><br>Copied By (initial): Date: |

| | | | |
|---|---|---|---|
| ☐ | Entered on Harmony | (initial): | Date: |
| ☐ | Welcome email sent to parent with instructions for accepting the enrolment on myGov | (initial): | Date |
| ☐ | Parent enrolment fee received | (initial): | Date: |