

# Blue Mountains Family Day Care Enrolment

## Welcome to the Blue Mountains Family Day Care Service

OFFICE USE ONLY	Harmony No: <b>F0</b>	TRIM No: <b>FDC</b>
-----------------	-----------------------	---------------------

NEW FAMILY: Invoice request sent	____/____/____	EXISTING FAMILY: No enrolment fee	
----------------------------------	----------------	-----------------------------------	--

Immunisation History Statement / Conscientious Objection	Received	____/____/____
--	----------	----------------

### IMPORTANT INFORMATION

In order to complete the enrolment of your child Blue Mountains Family Day Care is required to obtain all the information requested in this form. Your information will be kept confidential and secure by the service.

Enrolment cannot be completed without your Centrelink **Customer Reference Numbers** and your Immunisation History Statement. Immunisation information can be obtained from the Australian Childhood Immunisation Register, online or by calling 1800 653 809 or through the office of Medicare Australia: [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au)

<b>PARENT/GUARDIAN</b> (Family Assistance Office Registered)	
---	--

Your Customer Reference Number (CRN):		-		-	
---------------------------------------	--	---	--	---	--

Your Child's Customer Reference Number:		-		-	
---	--	---	--	---	--

All information provided is true and correct, I authorise Blue Mountains Family Day Care Service to process CCB and CCR payments on my behalf.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date: \_\_\_\_\_

**NSW immunisation laws state that children cannot be enrolled in child care, and CANNOT START care, unless they are fully immunised or have an approved exemption.**

Note: Children who are not immunised must be excluded from care during outbreaks of some infectious diseases in line with the National Health and Medical Research Council advice for recommended minimum exclusion periods for infectious conditions. During exclusion periods child care fees will be charged. Blue Mountains Family Day Care Service request updated immunisation status information on your child as your child continues with their next immunisation schedule.

Immunisation History Statement <b>UP TO DATE</b>	As at	____/____/____	OR	Conscientious objection	Dated	____/____/____
---	-------	----------------	----	-------------------------	-------	----------------

Educator enrolling : \_\_\_\_\_ Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

Failure to supply the relevant documentation could result in a fine.

<b>Child Care Benefit and Child Care Rebate</b>	For the purposes of FAMILY ASSISTANCE LAW care is provided, and fees are charged, by an educator on behalf of Blue Mountains Family Day Care. Child Care Benefit (CCB) and Child Care Rebate (CCR) are payments made to families by the Commonwealth Government to assist with the cost of their child care. As the approved service for purposes of claiming family assistance entitlements, payments are made by the Commonwealth Government to Blue Mountains Family Day Care and immediately transferred to the educator. For enquiries about entitlements contact the Family Assistance Office on telephone: 136 150.
---	--

<b>Priority of Access</b>	The demand for childcare sometimes exceeds supply. The Government has requested Services allocate places to those families with the greatest need for child support (refer to "priority of access" guidelines). Families will be given at least 14 days notice if the Service needs to use their place for a child with greater needs.
---------------------------	--

<b>Family Package</b>	The BLUE MOUNTAINS FAMILY DAY CARE FAMILY PACKAGE contains important information about the Service and is supplied as part of the enrolment process.
-----------------------	--

## PARENT/GUARDIAN (Registered with the Family Assistance Office)

Surname: \_\_\_\_\_ Given names: \_\_\_\_\_

Residential Address: \_\_\_\_\_ Postcode: \_\_\_\_\_

Home Tel No: \_\_\_\_\_ Mobile Tel No: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Email address: \_\_\_\_\_

Country of birth / Cultural Background: \_\_\_\_\_ Primary language: \_\_\_\_\_



Aboriginal/Torres Strait Islander



Occupation: \_\_\_\_\_ Full time / Part time (please circle)

Place of employment: \_\_\_\_\_ Work Tel No: \_\_\_\_\_

## OTHER PARENT/GUARDIAN

Surname: \_\_\_\_\_ Given names: \_\_\_\_\_

Residential Address (if different to above): \_\_\_\_\_ Postcode: \_\_\_\_\_

Home Tel No: \_\_\_\_\_ Mobile Tel No: \_\_\_\_\_

Country of birth / Cultural Background: \_\_\_\_\_ Primary language: \_\_\_\_\_



Aboriginal/Torres Strait Islander



Occupation: \_\_\_\_\_ Full time / Part time (please circle)

Place of employment: \_\_\_\_\_ Work Tel No: \_\_\_\_\_

## YOUR CHILD'S INFORMATION

Surname: \_\_\_\_\_ Given names: \_\_\_\_\_

Residential Address (if different to above): \_\_\_\_\_ Postcode: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: Male / Female

Country of birth / Cultural Background: \_\_\_\_\_ Primary language: \_\_\_\_\_



Aboriginal/Torres Strait Islander



Please specify 1 or 2 parent home: \_\_\_\_\_ School attending: (if applicable): \_\_\_\_\_

Medicare No: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (11 numbers) The number alongside your child's name on your card is the 11<sup>th</sup> number

## MEDICAL RECORD

Doctor's name: \_\_\_\_\_ Tel No: \_\_\_\_\_

Address: \_\_\_\_\_

### Relevant Health Information

Does your child have specific health needs? YES / NO

If YES please provide details on page 4 – "RELEVANT HEALTH INFORMATION, MEDICAL HEALTH PLANS"

### Development

Do you have any concerns about your child's development? (Circle if applicable)

Behavioural Development

Language Development

Overall Development

Please describe if applicable

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## EMERGENCY CONTACTS & AUTHORISED NOMINEES

*An authorised nominee is a person that you nominate to authorise medical treatment and/or the administration of medication and can authorise your educator to take your child outside the service in your absence.*

Name: \_\_\_\_\_ Tel No: \_\_\_\_\_ (hm/wk) Mobile: \_\_\_\_\_

Home Address: \_\_\_\_\_ Postcode: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Please tick

AUTHORISED NOMINEE

EMERGENCY CONTACT ONLY

Name: \_\_\_\_\_ Tel No: \_\_\_\_\_ (hm/wk) Mobile: \_\_\_\_\_

Home Address: \_\_\_\_\_ Postcode: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Please tick

AUTHORISED NOMINEE

EMERGENCY CONTACT ONLY

Name: \_\_\_\_\_ Tel No: \_\_\_\_\_ (hm/wk) Mobile: \_\_\_\_\_

Home Address: \_\_\_\_\_ Postcode: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Please tick

AUTHORISED NOMINEE

EMERGENCY CONTACT ONLY

## AUTHORISATIONS

I authorise an educator and/or staff member of Blue Mountains Family Day care to seek medical treatment for my child from a registered medical practitioner, hospital or ambulance service; and authorise transportation of my child by an ambulance service.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date: \_\_\_\_\_



## COURT ORDERS/PARENTING PLANS

Are there any court orders pertaining to this child? YES / NO

If any court orders, parenting orders or parenting plans apply please provide details below.

## RELEVANT HEALTH INFORMATION, MEDICAL HEALTH PLANS

### DETAILS OF ANY SPECIFIC HEALTHCARE NEEDS INCLUDING ANY MEDICAL CONDITION OR ALLERGIES:

---

---

---

A **MEDICAL HEALTH PLAN** from the treating doctor/health professional (A REGISTERED MEDICAL PRACTITIONER) must be provided.

**Medical Health Plan Received (date):** \_\_\_\_\_

**Details of your child's regular medication (if applicable):**

---

---

**Details of your child's dietary restrictions:**

---

---

## COURT ORDERS/PARENTING PLANS

1. Powers, duties, responsibilities or authorities of any person in relation to your child.

---

---

2. Details of access to your child (if applicable).

---

---

3. Details of court orders relating to your child's residence or contact with a parent or other person (if applicable).

---

---

Copies of court orders need to be provided to Blue Mountains Family Day Care Service

TYPE: COURT ORDER    PARENTING ORDER    PARENTING PLAN    OTHER:

**Received (date):** \_\_\_\_\_

