



# Beulah Matumbi

CHILD CARE CENTRE

186 Clovelly Road, Randwick NSW 2031 - Tel (02) 9665 3058 - Email: info@beulahmatumbichildcare.com.au

## ENROLMENT FORM

CHILD'S NAME \_\_\_\_\_ PREFERRED NAME \_\_\_\_\_

OTHER NAMES BY WHICH THE CHILD IS KNOWN \_\_\_\_\_

FORMER NAMES OF THE CHILD \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_

CRN \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_ POSTCODE \_\_\_\_\_

PHONE NO. (HOME) \_\_\_\_\_

CHILD'S MEDICARE NUMBER \_\_\_\_\_

DETAILS OF HEALTH FUND \_\_\_\_\_

Proof of child's place and date of birth (original birth certificate or passport) sighted  
by Director \_\_\_\_\_

### ATTENDANCE

#### DAYS

MON

TUES

WED

THURS

FRI

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#### HOURS


DATE OF ENROLMENT \_\_\_\_\_

**PARENT 1/GUARDIAN'S NAME** \_\_\_\_\_

OTHER NAMES BY WHICH THE PARENT MAY BE KNOWN \_\_\_\_\_

PARENT 1 DATE OF BIRTH \_\_\_\_\_

CRN \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

TEL NO \_\_\_\_\_ MOBILE NO \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

OCCUPATION/COURSE OF STUDY \_\_\_\_\_  
EMPLOYER/UNIVERSITY \_\_\_\_\_  
DEPARTMENT/SECTION \_\_\_\_\_  
BUSINESS ADDRESS \_\_\_\_\_  
TEL NO & EXTENSION \_\_\_\_\_

**PARENT 2/GUARDIAN'S NAME** \_\_\_\_\_

OTHER NAMES BY WHICH THE PARENT MAY BE KNOWN \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CRN \_\_\_\_\_

PARENT 2 DATE OF BIRTH \_\_\_\_\_

TEL NO \_\_\_\_\_ MOBILE NO \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

OCCUPATION/COURSE OF STUDY \_\_\_\_\_

EMPLOYER/UNIVERSITY \_\_\_\_\_

DEPARTMENT/SECTION \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

TEL NO & EXTENSION \_\_\_\_\_

**CUSTODIAL PARENT** (if applicable) \_\_\_\_\_

Access of other parent \_\_\_\_\_

Copy of Family Court or Injunctive Order detailing access arrangements: \_\_\_\_\_

**EMERGENCY CONTACT NO.S OTHER THAN PARENT:** In an emergency and/or if your child is still at the centre at closing time, we will contact these people to collect your child.

\*\*\*It is important that your emergency contacts live within 20 minutes drive of the centre.

1. NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE NO (H): \_\_\_\_\_ (BUS) \_\_\_\_\_ (MOB) \_\_\_\_\_

ADDRESS \_\_\_\_\_

2. NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE NO (H): \_\_\_\_\_ (BUS) \_\_\_\_\_ (MOB) \_\_\_\_\_

ADDRESS \_\_\_\_\_

3. NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE NO (H): \_\_\_\_\_ (BUS) \_\_\_\_\_ (MOB) \_\_\_\_\_

ADDRESS \_\_\_\_\_

**AUTHORISED PERSONS TO COLLECT CHILD OTHER THAN PARENT**

(NB. Staff must be notified if parent/s are unable to collect their child.)

1. NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE NO (H): \_\_\_\_\_ (BUS) \_\_\_\_\_ (MOB) \_\_\_\_\_

ADDRESS \_\_\_\_\_

2. NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE NO (H): \_\_\_\_\_ (BUS) \_\_\_\_\_ (MOB) \_\_\_\_\_

ADDRESS \_\_\_\_\_

3. NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE NO (H): \_\_\_\_\_ (BUS) \_\_\_\_\_ (MOB) \_\_\_\_\_

ADDRESS \_\_\_\_\_

### **HOME ENVIRONMENT**

COUNTRY OF BIRTH: PARENT 1. \_\_\_\_\_ PARENT 2 \_\_\_\_\_ CHILD \_\_\_\_\_

LANGUAGE/S SPOKEN IN THE HOME \_\_\_\_\_

FAMILY CUSTOMS THAT SHOULD BE RESPECTED \_\_\_\_\_

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

IS YOUR CHILD OF ABORIGINAL OR TORRES STRAIGHT ISLANDER DESCENT? \_\_\_\_\_

HAS YOUR CHILD BEEN CARED FOR BY PERSONS OTHER THAN PARENTS/GUARDIAN? GIVE  
DETAILS \_\_\_\_\_

\_\_\_\_\_

OTHER CHILDREN IN FAMILY:

	Name	Sex	Age (DOB)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

OTHER ADULTS LIVING IN THE HOME \_\_\_\_\_

\_\_\_\_\_

OTHER CLOSE RELATIONSHIPS (e.g. Grandparents, extended family) \_\_\_\_\_

\_\_\_\_\_

### **MEDICAL AND HEALTH**

CHILD'S DOCTOR'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CHILD'S DENTIST (If applicable) \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

### **HISTORY**

Any details that affect your child and his/her care (e.g. prematurity, hospitalisation, illness, separation etc.)

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

Has your child had a hearing test? Give details \_\_\_\_\_

\_\_\_\_\_

Any allergies to substances, food or medication? \_\_\_\_\_

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Does your child have a medical condition, including allergies, asthma, diabetes or anaphylaxis? Y/N  
If yes, I have been given the centre's Medical Conditions policy, Risk Minimisation Plan and  
Communication Plan?      Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Dietary restrictions:**      Medical \_\_\_\_\_  
   Religious \_\_\_\_\_  
   Other \_\_\_\_\_

Is your child receiving regular medication e.g. for asthma. Give details of what/when/why \_\_\_\_\_

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Does this medication have any side effects which staff should be aware of? \_\_\_\_\_

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Please list any other foods that are of significant like/dislike for your child \_\_\_\_\_

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**INSURANCE**

The Centre has insurance cover with Guild (Kindergarten) Insurance as required by law and Regulations covering Centre Based Child Care.

**ENROLMENT FEE/BOND**

The enrolment fee/bond will be \_\_\_\_\_ for 1 child in care, \_\_\_\_\_ for 2 children and \_\_\_\_\_ for 3 children.  
The bond is refundable when all the following conditions are met: (1) that the child commences care, (2)  
that the child completes at least 8 weeks of care and (3) that 4 weeks' notice is given before the child is  
withdrawn from care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**DAILY FEES (per day)**

For: 0-2 year olds is \$ \_\_\_\_\_  
For: 2 year olds is \$ \_\_\_\_\_  
For 3-5 year olds is \$ \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**INFORMAL OUTINGS**

Ongoing and one off excursion authorisation will be attained prior to excursions, in accordance with Education and Care Services National Regulations 99 & 102.

I hereby consent to the Centre escorting my child outside the boundaries of the Centre grounds for Emergency Evacuation practice drills. These will occur every 3 months.

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

**TRANSPORT**

Do you authorise the child being transported by the service or on transportation arranged by the service? (Please indicate as “not applicable” the use of regular transport by the centre of your child as we do not offer this service.)

\_\_\_\_\_

**PHOTOGRAPHS**

I do/do not consent to photographs being taken of my child by staff or student for the purpose of observing and documenting your child's learning.

I agree to not redistribute photos sent to me from Beulah Matumbi to any other person or source.

Parent 1: Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent 2: Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NEWSLETTER**

I do/do not consent to the centre's monthly newsletters being received via MailChimp (both parent/guardian email addresses provided will be added to the mail list)

**MEDICAL**

In the event of an emergency, illness or accident involving my child and the Centre being unable to contact me or another person so authorised by me, I consent to the Centre seeking, on my behalf, medical or hospital attention for my child and I accept liability for medical expenses as may be incurred. I understand that ambulance costs will be covered by the Centre’s membership of the Health Commission of N.S.W. Ambulance Service.

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

In the event of an emergency, the following person/s is to be contacted if any parent cannot be immediately contacted.

Name of Person/s \_\_\_\_\_

In the event of an emergency or accident, I consent to the Centre seeking, on my behalf, urgent dental treatment for my child and I accept liability for dental expenses as may be incurred.

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

To reduce fever or pain, in alignment with 'Managing A Child With Acute Fever Policy', I hereby consent for the Centre to:

- a. Administer the correct dosage of paracetamol

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

- b. Administer tepid baths or sponging

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

## **ROUTINES**

TOILETING:	Independent	Needs Assistance	Term used
SLEEPING:	Soundly	Restless	Day Sleep
COMFORTER:	Thumb	Rug	Favourite Toy
OTHER:	_____		

I consent to my child sleeping during rest time at the Centre.

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

I have read the Parent Handout and agree to centre's policies and undertake to abide by any changes thereafter.

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

## **AUTHORITY FORMS**

### **AGREEMENTS AND AUTHORISATION**

1. I give permission for an ambulance and/or doctor to be called for my child \_\_\_\_\_ in case of an accident or emergency and I accept full responsibility for all expenses incurred.

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

I understand that the Director and staff of Beulah Matumbi must be given prior notice when authorised people (other than parent/s) will be collecting my child. I also undertake to make these people known to the Director and staff before the collection of my child. If people collecting are unknown to the staff, a photo ID will be required.

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

To provide safety for children around Beulah Matumbi, I hereby agree and undertake to abide by the following:

- a. not to park my vehicle on the bus stop
- b. not to double park my vehicle around Beulah Matumbi
- c. to use parking available beyond the front of the school.

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