107 Brook St Coogee 2034 | **ABN**: 93285345482
info@miriskindy.com.au | (ph) 0411 743 783

Miri's Créche
IT TAKES A VILLAGE TO RAISE A CHILD

Enrolment form

Please complete all information. Enrolments will not be considered without a completed form

Child's Given Name …… Nick Name …….
Child's Family Name……..**C.R.N:** ……
Childs former name if applicable…… **D.O.B** ……
M / F…… ……. Place of birth……
Address…….
……

Home Phone……Religion……..
Primary Language…….Cultural Background……Legal Guardian……..

Is there anyone who is prohibited from having contact with or collecting the child?
……court orders pls attach……

Days Req'd: please circle M: T: W: TH: F: Start Date req'd…….

Medicare number:……. Health Fund Name and Number:……..

Mothers Given Name…… Family Name……**CRN**:……..
Phone (H)…… Phone (Mobile)……...**DOB**…….
Address:……..
Email:……Fax:……..
Work details mother: Employer:……..
Phone(W)……Hours…… Occupation:……..
Primary language……other languages…….
Mothers maiden name……

Father's Given Name……Nick Name……Family Name……
Phone: (H)……..Phone (Mobile)……..
Address:……..
Email……Fax:……..
Work Details Father: Employer:……
Phone (W)……Hours……Occupation…….
Primary language……..other languages……..

Immunisation Details:
Please supply a copy of your childs birth certificate and your child's current Immunisation form. This can be accessed from your medicare mygov website. No other form is acceptable Birth certificate cited. : YES……..NO:……. This is a regulatory requirement.

Medical Details: Is your child on regular medication or have any disabilities, food sensitivities or allergies we should know about? YES / NO
If Yes give details……
If yes to allergies requiring an Epipen please complete action form

Is there any other information you wish us to know about your child?……..
Has your child had any of the following? Y/N Measles……German Measles…. Ear Infection……
Epilepsy ……..Asthma…… Hepatitis….Mumps….Chicken Pox….Throat Infection….
If yes to asthma please complete an asthma action form.

Emergency Details:
Doctor's Name……Ph: No: …… Release child to Dr:Y/N……..
Address……..
Dentists name ……..Ph: No:…… Release child to Dentist Y/N…..

Using the space below list at least 2 people authorised to collect the child and at least 2 people that we may call if we cannot find you in an emergency. These may be the same people for both:

Any person who is authorised to consent to medical treatment of, or to authorise administration of medication to the child: Y/N Name: Y/N Name:

Any person who is authorised to authorise an educator to take the child outside the education and care service premises: Y/N Name: Y/N Name:

Any person who is authorized to authorize for education and care service to transport the child or arrange transportation of the child. Y/N Name: Y/N Name:

1.Persons Name ……..Relationship ……Phone(H)……
Phone (W)……Phone Mobile……Emerg. Release Y/N…..
Daily P/U Y/N…. Home Address……
Work Address ……

2.Persons Name ……..Relationship …… Phone (H)…… Phone (W)……Phone Mobile……Emerg. Release Y/N…..
Daily P/U Y/N…. Home Address……
Work Address ……

3.Persons Name ……..Relationship ……Phone (H)…… Phone (W)……Phone Mobile……Emerg. Release Y/N…..
Daily P/U Y/N…. Home Address……
Work Address ……

In the event of an emergency , illness or accident concerning my child and the teacher being unable to contact me or other persons so authorised by me, I consent to the Centre seeking on my behalf medical, dental, hospital & ambulance attention and transportation for my child and I accept liability for medical ,dental hospital & ambulance as may be incurred

Parents Signature……Date……

Parking Details:

I have read and understood all parking requirements limitations and restrictions. I will park only in the legal parking areas and bays as permitted by the RTA and Council Requirements and restrictions.

Parents Signature……..Date……