



## Fernhill Road After School and Vacation Care

### ENROLMENT DETAILS

Child's Room: - *After School Care/Vacation Care*

Child's day's:- *Mon/Tue/Wed/Thu/Fri*

Name of School attended: \_\_\_\_\_

Child's start date: \_\_\_\_\_

Family C.C.B %: \_\_\_\_\_ No. of Children in Care \_\_\_\_\_

Administration Fee \$ 50.00

Refundable Bond(Equivalent to 2 Weeks ASC) .....\$ \_\_\_\_\_

Two Weeks Fee in advance (ASC only) .....\$ \_\_\_\_\_

**TOTAL AMOUNT TO BE PAID ON ENROLMENT** \$.....

**(Your child's place will not be secured until advanced Fees have been Paid)**

Estimated Normal Weekly Fee \$ \_\_\_\_\_

#### Payment Options:

Cash  
Eftpos  
Cheque

Credit Card  
Netbank  
Direct Debit(from Credit card)

#### Mailing Address

8 Fernhill Rd  
Port Macquarie  
N.S.W 2444  
Phone: 6581 2424  
Fax: 6581 2337

#### Bank Account Details

National Australia Bank  
Port Macquarie  
B.S.B- 082 798  
Account number – 570 527 736

**Service number: ..... 407 125 377J**

**Family Assistant Office: 136150**

**PLEASE PROVIDE IMMUNISATION DETAILS  
AND BIRTH CERTIFICATE UPON ENROLMENT**

# Fernhill Rd Preschool Long Day Care Centre

8 Fernhill Road PORT MACQUARIE NSW 2444 Tel: (02) 65 81 2424

## Enrolment Form

Child's Given Name: ..... Child's Family Name: .....

Other Names the Child is known by: .....

Other Names the Child has been known by: .....

M / F: ..... DOB: ..... Address: .....

Place of Birth: .....

Home Phone: ..... Bill Fees To: .....

Legal Guardian: ..... Religion: .....

Indigenous Status: .....

Primary Language: ..... Cultural Background: .....

Special Needs (Y/N) ..... Disability (Y/N): .....

Is there anyone who is prohibited from having contact with or collecting the child? .....

Days Req'd Mon Tues Wed Thur Fri Hours of Care Req'd ..... Start Date Req'd .....

### Information required to claim CCB:

CCB Hours Nominated (Y/N): ..... If Yes - Hours to be used in this Centre: .....

Child's CRN:

Parent/Guardian/Claimant Name: .....

Parent/Guardian/Claimant Date of Birth: ..... CRN:

**Important: Please make sure that the Parent/Guardian/Claimant Date of Birth, and the Parent/Guardian/Claimant CRN are for the person claiming CCB.**

Mother's Given Name: ..... Mother's Family Name: .....

Other Names the Mother is known by: .....

Other Names the Mother has been known by: .....

Address: .....

Home Phone: ..... Mobile Phone: .....

Email Address: .....

**Work Details Mother:** Employer: ..... Suburb: .....

Phone (W): ..... Hours: ..... Occupation: .....

Father's Given Name: ..... Father's Family Name: .....

Other Names the Father is known by: .....

Other Names the Father has been known by: .....

Address: .....

Home Phone: ..... Mobile Phone: .....

Email Address: .....

**Work Details Father:** Employer: ..... Suburb: .....

Phone (W): ..... Hours: ..... Occupation: .....

**Medical Details:**

Does your Child take regular medication or have any disabilities, food sensitivities or allergies we should know about? Yes/No

If Yes give details: .....

Is there any other information you wish us to know about your child? .....

Has your Child had any of the following? Y/N

Measles	<input type="checkbox"/>	German Measles	<input type="checkbox"/>	Ear Infection	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Throat Infection	<input type="checkbox"/>		<input type="checkbox"/>

Medicare No: ..... Private Health Particulars: .....

**Emergency Details:**

Doctor's Name: ..... Phone No: ..... Contact Doctor Y/N .....

Address: .....

Dentist's Name: ..... Phone No: ..... Contact Dentist Y/N .....

Religious Requirements in case of Accident: .....

Using the boxes 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 situations.

Person's Name	Relationship to Child	Phone (H)	Phone (W)	Phone (Mobile)	Emerg. Release Y/N	Daily Pick Up Y/N

Home Address: .....

Work Address .....

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Home Address: .....

Work Address .....

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Home Address: .....

Work Address .....

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Home Address: .....

Work Address .....

In the Event of an emergency, illness or accident concerning my child, I consent to the service seeking on my behalf urgent medical, dental, hospital and ambulance services for my child and I consent to the carrying out of appropriate medical, dental or hospital treatment in the event that such action appears to be necessary because my child has been injured, or is ill, at the premises. I accept any liability for medical, dental, hospital and ambulance that may be incurred.

I understand that the authorised supervisor of the service will, as soon as practically possible, notify me or other persons so authorised by me of the accident or illness and the treatment or services arranged for my child.

Parent Signature ..... Date .....

**Please supply evidence of immunisation - either your Blue Book or a letter from your doctor.**

## Supplementary Enrolment Questions

1. I agree to my child's photograph being used for digital documentation and publicity for the centre.

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2. I will apply sunscreen before arrival & give permission for staff to re-apply sunscreen to my child.

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3. I hereby acknowledge that I have received the Information Sheet and agree to abide by its policies.

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4. Is your child Immunized? I agree to supply proof of my child's immunisation.

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5. Is there any other information you wish us to know about your child? e.g routines/allergies etc.

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6. I agree to pay my fees two weeks in advance (ASC only)

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7. If headlice is suspected in the centre, I give permission for my child's hair to be checked.

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8. In an emergency eg High temp,I give permission for my child to be given panadol if I'm uncontactable.

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Parent Signature:.....Date:.....

