13 Alfred Street
Walkerville SA 5081
Phone: 08 8344 8995
Email: 123@walkervilleprekindy.com.au

Enrolment Form

Child's Details

Surname _____ First Names _____

Preferred Name _____ Gender (Please Circle) Male Female Date of Birth _____

Residential Address _____

Primary Language(s) spoken at home _____

Primary Parent / Guardian Details

Name_____

Relationship to child _____

Residential Address _____

Occupation _____

Work Address_____

Home Phone _____ Work Phone _____ Mobile _____

Email _____ Language(s) spoken at home _____

Primary Parent / Guardian Details

Name _____

Relationship to child _____

Residential Address _____

Occupation _____

Work Address_____

Home Phone _____ Work Phone _____ Mobile _____

Email _____ Language(s) spoken at home _____

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Emergency Contacts & Authority to Collect

Primary Contact

Name_____

Relationship to child _____

Residential Address _____

Occupation _____

Work Address_____

Home Phone _____ Work Phone _____ Mobile _____

Authority to Collect (please circle) Yes No

Secondary Contact

Name_____

Relationship to child _____

Residential Address _____

Occupation _____

Work Address_____

Home Phone _____ Work Phone _____ Mobile _____

Authority to Collect (please circle) Yes No

Medical & Health Information

Has your child received the following immunisations? (Please circle)

2 Months	Triple Anitgen/Polio/Hib (a,b,c)	Yes / No
4 Months	Triple Anitgen/Polio/Hib (a,b,c)	Yes / No
6 Months	Triple Anitgen/Polio/Hib (b,c)	Yes / No
12 Months	Measles/Mumps/Rubella/Hib (a)	Yes / No
18 Months	Triple Anitgen/Polio/Hib (a,b,c)	Yes / No
4-5 Years	Diphtheria Tetanus Polio Booster	Yes / No

To be eligible for Child Care Assistance and Child Care Rebates, children under 7 are required by the commonwealth to be immunised.

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Medical & Health Information

Does your child have any disabilities or medical conditions? If yes, please specify.

_____

_____

_____

_____

_____

_____

Does your child usually require regular medication or special aids (eg. glasses, hearing aids etc. If so a health support plan may be required).

_____

_____

_____

_____

_____

Has your child suffered any illness that may re-occur?

_____

_____

_____

_____

Family Doctor

Family Doctor's Name _____ Phone _____

Clinic Name _____

Address _____

Medical Benefits Cover Company _____

Medicare Number _____

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Medical & Health Information

Does your child have any allergies? (Food, Insects, Plants, Antibiotics etc) Please specify.

_____

_____

_____

_____

_____

_____

Is there any other medical information Walkerville Pre-Kindy might need to know?

_____

_____

_____

_____

_____

Are there any special, non-medical requirements we need to know?

_____

_____

_____

_____

Declaration

I/We give my permission for the licensee and staff of this centre to obtain emergency medical hospital or ambulance services at any time they consider they deem necessary. I understand that I will be notified as soon as possible if medical, hospital or ambulance services are required. I acknowledge that I will be liable for any medical/hospital/ ambulance expenses incurred in the treatment of my child whilst in the care of Walkerville Pre-Kindy.

Primary Parent/Guardian Signature _____ Date _____

Secondary Parent/Guardian Signature _____ Date _____

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Your Child's Program

To enable Walkerville Pre-Kindy to plan our program around your child's interests and developmental needs, we would appreciate the following information.

Does your child have any particular interests that you would like to share with us?

Are there any problems or concerns you would like to make us aware of?

What expectations do you have for your child at Walkerville Pre-Kindy?