



369 MARMION STREET
 MELVILLE WA 6156
 CALL 08 9317 4467
 MOBILE 0432 062 396
 WWW.CHILDRENS.GARDEN



PARENT ENROLMENT FORM:

PARENT 1	PARENT 2
TITLE/FIRST NAME:	TITLE/FIRST NAME:
LAST NAME:	LAST NAME:
DATE OF BIRTH:	DATE OF BIRTH:
DRIVERS LICENCE NUMBER:	DRIVERS LICENCE NUMBER:
ALIAS:	ALIAS:
HOME ADDRESS:	HOME ADDRESS:
POSTAL ADDRESS:	POSTAL ADDRESS:
HOME PHONE:	HOME PHONE:
MOBILE:	MOBILE:
EMAIL ADDRESS:	EMAIL ADDRESS:
ETHNICITY:	ETHNICITY:
LANGUAGE SPOKEN:	LANGUAGE SPOKEN:
MARITAL STATUS:	MARITAL STATUS:
CRN:	CRN:

EMPLOYMENT DETAILS:

OCCUPATION:	OCCUPATION:
WORK NAME:	WORK NAME:
WORK ADDRESS:	WORK ADDRESS:
WORK PHONE:	WORK PHONE:
EMAIL ADDRESS:	EMAIL ADDRESS:
COMMENTS:	COMMENTS:

MEDICAL DETAILS:

DOCTOR:	DENTIST:
ADDRESS:	ADDRESS:
PHONE:	PHONE:
MEDICARE NUMBER:	MEDICARE NUMBER:
HEALTH CARE FUND NO:	HEALTH CARE FUND NO:

I HEREBY GIVE MY WRITTEN CONSENT TO THE CARRYING OUT OF APPROPRIATE MEDICAL, DENTAL, AMBULANCE OR HOSPITAL TREATMENT, IN THE EVENT THAT SUCH ACTION APPEARS TO BE NECESSARY BECAUSE THE CHILD HAS BEEN INJURED, OR IS ILL, AT THE PREMISES.
 NOTE: NOTHING IN THIS CLAUSE LIMITS THE AUTHORITY OF A MEDICAL PRACTITIONER OR DENTIST TO CARRY OUT EMERGENCY MEDICAL OR DENTAL TREATMENT ON A CHILD WITHOUT THE CONSENT OF THE CHILD'S PARENT AS REFERRED TO IN SECTION 174 OF THE ACT.

SIGNED BY THE PARENT:	DATED:	
DATE:	SIGNED:	WITNESS:

MISCELLANEOUS:

OTHER CHILDREN LIVING AT HOME (NAME & AGES - OPTIONAL):

CAN YOU CONTRIBUTE ANY SKILLS TO OUR CENTRE'S PROGRAM OR HAVE TIME TO VOLUNTEER, E.G. SEWING, TYPING, MAINTENANCE ETC?

OTHER COMMENTS:

SIBLINGS ATTENDING OTHER CENTRE:

FIRST NAME:

FIRST NAME:

FIRST NAME:

LAST NAME (IF DIFFERENT):

LAST NAME (IF DIFFERENT):

LAST NAME (IF DIFFERENT):

ARE YOU CLAIMING CCS FOR THIS CHILD?

ARE YOU CLAIMING CCS FOR THIS CHILD?

ARE YOU CLAIMING CCS FOR THIS CHILD?

EMERGENCY CONTACTS: (DO NOT INCLUDE PARENTS NAMES)

I AUTHORISE THE STAFF OF THIS CENTRE TO GIVE THE FOLLOWING EMERGENCY CONTACT NAMES ACCESS TO MY CHILD/REN: (NOTE: MUST BE OVER 18 YEARS). PLEASE ENSURE THESE EMERGENCY CONTACT PERSONS ARE WILLING AND ABLE TO COLLECT YOUR CHILD/REN IN THE EVENT OF AN EMERGENCY. AT LEAST 2 CONTACT NAMES MUST BE COMPLETED BEFORE ENROLMENT COMMENCES.

1. EMERGENCY CONTACT

2. EMERGENCY CONTACT

3. EMERGENCY CONTACT

FIRST NAME:

FIRST NAME:

FIRST NAME:

LAST NAME (IF DIFFERENT):

LAST NAME (IF DIFFERENT):

LAST NAME (IF DIFFERENT):

ADDRESS:

ADDRESS:

ADDRESS:

HOME PHONE:

HOME PHONE:

HOME PHONE:

MOBILE:

MOBILE:

MOBILE:

WORK NAME:

WORK NAME:

WORK NAME:

ADDRESS:

ADDRESS:

ADDRESS:

WORK PHONE:

WORK PHONE:

WORK PHONE:

RELATIONSHIP TO CHILD:

RELATIONSHIP TO CHILD:

RELATIONSHIP TO CHILD:

NOTE: THE STAFF WILL NOT ALLOW YOUR CHILDREN TO GO WITH ADULTS UNLESS NAMES ARE WRITTEN ON THIS FORM

AUTHORITY TO COLLECT: (DO NOT INCLUDE PARENTS NAMES)

I AUTHORISE THE STAFF OF THIS CENTRE TO GIVE THE FOLLOWING EMERGENCY CONTACT NAMES ACCESS TO MY CHILD/REN: (NOTE: MUST BE OVER 18 YEARS). PLEASE ENSURE THESE CONTACT PERSONS ARE WILLING AND ABLE TO COLLECT YOUR CHILD/REN IN THE EVENT OF AN EMERGENCY. AT LEAST 2 CONTACT NAMES MUST BE COMPLETED BEFORE ENROLMENT COMMENCES.

1. COLLECT/PICKUP/CONTACT

2. COLLECT/PICKUP/CONTACT

3. COLLECT/PICKUP/CONTACT

FIRST NAME:

FIRST NAME:

FIRST NAME:

LAST NAME (IF DIFFERENT):

LAST NAME (IF DIFFERENT):

LAST NAME (IF DIFFERENT):

ADDRESS:

ADDRESS:

ADDRESS:

HOME PHONE:

HOME PHONE:

HOME PHONE:

MOBILE:

MOBILE:

MOBILE:

WORK NAME:

WORK NAME:

WORK NAME:

ADDRESS:

ADDRESS:

ADDRESS:

WORK PHONE:

WORK PHONE:

WORK PHONE:

RELATIONSHIP TO CHILD:

RELATIONSHIP TO CHILD:

RELATIONSHIP TO CHILD:

NOTE: THE STAFF WILL NOT ALLOW YOUR CHILDREN TO GO WITH ADULTS UNLESS NAMES ARE WRITTEN ON THIS FORM

AGREEMENT:

FEES MUST BE PAID ON DUE DATE AND ALWAYS BE 2 WEEKS IN ADVANCE.

SIGNED BY THE PARENT:

DATED:

DATE:

SIGNED:

WITNESS: