



## School Holiday Program Enrolment Form: January 2018

**This information is confidential and all privacy will be respected**

The purpose of this form is to help us adequately prepare for your child’s participation in NCIE programs. This information is **confidential** and students will not be excluded for medical reasons. By providing accurate information you are ensuring your child’s safety and wellbeing.

### Child Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Child CRN: \_\_\_\_\_ D.O.B: \_\_/\_\_/\_\_\_\_\_

Gender: \_\_\_\_\_ Custody Particulars: \_\_\_\_\_

Is your child Aboriginal or Torres Strait Islander?  YES, Aboriginal  YES, Torres Strait Islander  YES, both  NO

Country of Birth \_\_\_\_\_ Ethnicity \_\_\_\_\_

First Language \_\_\_\_\_ Second Language \_\_\_\_\_

Does NCIE need to be aware of any special Cultural or religious requirements?

Is your child at risk or are there any access restrictions, court restrictions, parenting orders or parenting plans that NCIE need to be made aware of? Please list: \_\_\_\_\_

**In order to secure your place, please confirm which days your child/children will be attending**

MON 8 <sup>th</sup> January	TUE 9 <sup>th</sup> January	WED 10 <sup>th</sup> January	THU 11 <sup>th</sup> January	FRI 12 <sup>th</sup> January	MON 15 <sup>th</sup> January	TUE 16 <sup>th</sup> January	WED 17 <sup>th</sup> January	THU 18 <sup>th</sup> January	FRI 19 <sup>th</sup> January

### Child’s Medical Information

Child Medicare No: \_\_\_\_\_ Valid to: \_\_\_\_\_

Doctor’s Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Are you a member of the Redfern Aboriginal Medical Service (AMS)?  YES  NO

<b><u>MEDICAL HISTORY</u></b>	Please tick either <b>Yes or No</b> to all Questions		<b>Provide detailed information:</b> <i>How serious is it? What is it? When? Has it fully recovered? Any known triggers? Is it self managed? Anticipated special management needed? <u>This information is confidential all privacy will be respected</u></i>		
Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If YES, request an <b>“Asthma Management Form”</b>		
Allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If YES, request an <b>“Allergenic Reaction Management Form”</b>		
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If YES attach current management/care plan. A fitness to participate form signed by treating doctor will also be required.		
Epilepsy	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Joint/muscle/bone problems?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Sight/hearing impairment	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Any serious injuries/illness in the last 12 months?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Is your child currently on any medications?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>Please name the medication and dosage</i>		
Other medical condition that may affect participation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>Any health issue that require attention or special care?</i>		
Other: learning issues, psychological, emotional or behavioural issues?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>Please add details to assist in understanding and managing the student</i>		
Please provide authorised consent for any medical treatment or administration of medicine					
Sign: _____ Date: _____					
<b><u>DIETARY</u></b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If vegetarian, does your child eat fish or white meat?		
Any special requirements?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
<b><u>SWIMMING ABILITY</u></b>	<input type="checkbox"/> No		<input type="checkbox"/> with a struggle	<input type="checkbox"/> Comfortably	<input type="checkbox"/> Strongly
My child can swim 50 metres					
I declare that the information, which I have provided, on this form is complete and correct and <u>that I will notify the NCIE if any changes occur</u> . I authorise any employee of NCIE who is with my child, to give consent where it is impractical to communicate with me, and agree to my child receiving such medical or surgical treatment as may be deemed necessary. I give permission for NCIE to pass this information to a third party [e.g. Doctor, Hospital] to facilitate the medical treatment of my child. I give permission for NCIE to retain this form for statutory archival requirements.					
Signed: _____ (Parent/Guardian)      Date: _____					

## Parent/Guardian

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Parent/Guardian CRN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Mobile): \_\_\_\_\_

Address:

\_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_

## Partner:

Full Name: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Mobile): \_\_\_\_\_

Address:

\_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_

## Emergency Contacts

**This information is confidential all privacy will be respected**

Please note NCIE Staff can only allow children to be picked up and dropped off by **authorised emergency pick up contacts**.

### 1. Parent or Guardian/Emergency Contact (Child pick-up authorisation):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Mobile): \_\_\_\_\_

Address:

\_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_

**2. Emergency Contact (Child pick-up authorisation):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Mobile): \_\_\_\_\_

Address:

\_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_

**3. Emergency Contact (Child pick-up authorisation):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Mobile): \_\_\_\_\_

Address:

\_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_

**4. Emergency Contact (Child pick-up authorisation):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Mobile): \_\_\_\_\_

Address:

\_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_