



CHILD CARE CENTRE

ABN 59 127 784 016

10a Branyan Street, Bundaberg, Qld, 4670. Phone 4153 0300 Fax 4153 0307

Acorn Babies Enrolment Form

Child Details

Surname		First name		Date of birth / /		Male <input type="checkbox"/>		Female <input type="checkbox"/>	
Address				Primary Language Spoken		Primary Family Language			
Centre Start Date / /		Age of Child at Enrolment Years <input type="text"/> Months <input type="text"/>		Do you hold a Health Care Card? Yes <input type="checkbox"/> No <input type="checkbox"/>		Health Care Card number			
Child's CRN (Centre Link Reference Number)				Are there court orders affecting your child? Yes <input type="checkbox"/> No <input type="checkbox"/>		Nationality			
				(If so, please attach a copy of these to this enrolment form)					
Attendance Days Required for your Child (Please include drop off and pick up times)									
Monday		Tuesday		Wednesday		Thursday		Friday	

List any allergies or significant medical issues effecting your child		Does your child have any special needs, disabilities or does your child have any special cultural or religious requirements? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Please tick immunisations							
	0	2M	4M	6M	12M	18M	4Y
Hep B	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dip/Tet/WC	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hib	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococca	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MMR	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mening. C	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chickenpox	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If the parent/s or emergency contact listed cannot be contacted, I authorise the staff to take all reasonable steps to provide appropriate medical attention to my child and seek further medical, dental or hospital treatment and/or ambulance and give paracetamol.

Signed _____ Dated ___/___/___

May staff members photograph your child?	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
No <input type="checkbox"/>	Signed _____

Family Doctor	
Name	Phone
Medicare Card Number	

Parent / Guardian 1 - Claiming CCB

Surname		Date of Birth	
First Name			
Relationship to Child		Responsible for Fees Yes <input type="checkbox"/> No <input type="checkbox"/>	
Mobile Phone			
Home Phone		Work Phone	
Email Address			
Address (home)			
		Employed by	
Do you have a child attending any other child care services or at Acorn Babies? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Your CRN			

Parent / Guardian 2

Where information is the same as Parent 1, please tick box

Surname		Date of Birth	
First Name			
Relationship to Child		Responsible for Fees Yes <input type="checkbox"/> No <input type="checkbox"/>	
Mobile Phone Number			
Home Phone Number		Work Phone Number	
Address (home)			
		Sign Child In? Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Contact with Child? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Email Address			
Employed by			

Other Emergency Contacts

Name	Relationship to Child	Mobile Phone Number	Home Phone Number	Work Phone Number	Address	Can this contact pick up your child?	Can this contact sign in your child?
						Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>