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| **When did your child/ren last attend a school holiday program run by NI Connect (please provide month and year)?**  **--------------------------------------------------------------** |
| **Child’s Name** | **Date of Birth** | **Age** | **M/F** | **Class** |
|  |  |  |  |  |
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| **PARENTS/GUARDIANS INFORMATION** |
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| --- | --- | --- | --- | --- | --- | --- |
|  | **Full Name** | **Date of Birth** | **Daytime/Work Phone** | **Mobile** | **Please indicate if you are working full time or part time. If Part time indicate approx. hours per week****FT PT No of hrs**  |  |
| 1.Mother |  |   |  |  |  |  |
| 2.Father |  |   |  |  |  |  |
| 3.Joint Carer |  |   |  |  |  |
| **Please advise who of the above people is the preferred contact**  |
| Home Address |  | Home Phone | Alternate/emergency contact |
| Home Address (alternate) |  |  |  |
| Email 1. |  |  |  |
| Email 2. |  |  |  |
| Email 3. |  |  |  |
| Custody / Parenting / Domestic Violence orders or plans (of which to be aware)If yes please ensure a copy is provided to the service |  |

**I give the following emergency contacts authorization to, either one, any or all of the following, if I cannot be contacted:** 1. Collect child
2. Consent to medical treatment
3. Consent to seek treatment from registered medical practitioner/ hospital/ ambulance
4. Consent to seek transportation of the child by an ambulance service

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| --- | --- |
| **Emergency Contacts** |  |
| Full Name | Address  | Mobile/ Phone | Consent Given to: (Please circle) | **Mobile** |
|  |  |  | 1 2 3 4  |  |
|  |  |  | 1 2 3 4  |  |
| **Parent Name** |  | **Signature** |  |  |

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| Any special cultural, religious or dietary considerations or additional needs (e.g. disability, incontinence issues, difficulty socialising in groups etc.) |  |
| Cultural Background |  | Language used in child’s home |  |
| How well would you rate your child’s swimming ability: | Weak | Medium | Strong |
| What are your child’s hobbies and interests? |  |

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|  | **Medical/Health Information Child 1,2,3,4,5** |
| Has any of your children had any serious illness in the past? | Yes/No | **If yes please provide details** |
| Has any of your children ever been hospitalised? | Yes/No |  |
| Do any of your children currently have a serious illness? | Yes/No |  |
| Do any of your children require any medical procedures/intervention to be performed on a regular basis? | Yes/No |  |
| Is any of your children receiving regular medication? | Yes/No |  |
| Do the medication have any side effects that staff need to be aware of? | Yes/No |  |
| Do any of your children have Asthma?  | Yes/No | If yes please attach a copy of your Child’s Asthma Management Plan |
| Do any of your children have any allergies (including allergies to sunscreens, antiseptics, nuts, strawberry’s, eggs etc)? | Yes/No |  |
| If yes to any of the above, is any of your children’s allergic reaction likely to result in anaphylaxis? If yes, what actions need to be undertaken | Yes/No | If yes please attach a copy of our child’s anaphylaxis Action Plan |
| Do any of your children have epilepsy? | Yes/No | If yes, please attach a copy of your child’s Epilepsy Management Plan. |
| Doctor/GP Clinic | **General Practice Clinic** |
| Address | **2 Grassy Road, Norfolk Island** | Phone Number | **24134** |
| Child/children’s Medicare Number | Child 1:Child 2:Child 3:Child 4:Child 5: |
| **Immunization Status Up-to-Date Yes/No** **IF YOU HAVE PREVIOUSLY PROVIDED YOUR CHILD’S CURRENT IMMUNISATION RECORD TO US, PLEASE ADVISE:*** **When did you provide the record to NI Connect?**

**Please attach a copy of your child’s immunisation record if not already provided previously.**If No record is provided, we need a letter from a GP or your child will be excluded if any infectious disease outbreaks occur. |

**Use of Child’s photographs and videos:**

I agree that photographs and videos of my child taken at the HWP maybe used in NI-Connect and/or Key Assets publications, website or for other promotional and education purposes**. YES/NO**

**Please tick the days/sessions that you consent to your child attending:**

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| --- |
| **WEEK ONE** |
|  | Monday  | Tuesday  | Wednesday  | Thursday  | Friday  |
| Morning session | No program this date |  |  |  |  |
| Afternoon session |  |  |  |  |  |
| **WEEK TWO** |
|  | Monday  | Tuesday  | Wednesday  | Thursday  | Friday  |
| Morning session |  |  |  |  | No program on this date |
| Afternoon session |  |  |  |  |  |
| Do you consent to your child/ren being transported to various venues as required? | Please circle:YES NO |
| **Signature:****Print Name:****Date:** | **Signature:****Print Name:****Date:** |

**OFFICE USE ONLY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date enrolment form received:** |  | **Staff name** | **Staff signature** |
|  | **Copies attached**  | **Not applicable/comments** | **Staff signature** |
| **Court orders** i.e.Custody / Parenting / Domestic Violence |  |  |  |
| **Asthma Action Plan** |  |  |  |
| **Allergy plan** |  |  |  |
| **Epilepsy Action Plan** |  |  |  |
| **Anaphylaxis Action Plan** |  |  |  |
| **Immunisation Record** |  |  |  |
| **Date enrolment confirmed:** |  | **Staff name** | **Staff signature** |