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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** | | | | |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | **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  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **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**

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| --- | --- | --- | --- |
| **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** |