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**2018 ENROLMENT RECORD**

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| **Parent/Guardian – Please Read Carefully**  **The Education and Care Services National Regulations (Regulations 160, 161 and 162), requires all licensed children’s services to keep an enrolment record for each child. The information on this form is vital to the safety and wellbeing of your child. It will also assist in the development of your child’s program to ensure that it reflects the needs of your child. This form is considered a legal document and therefore must be filled in correctly.**  Please ensure you complete all sections applicable to you and your child and that all appropriate areas are signed.   * *N.B: Only biological or legal guardians can be listed in the parent/guardian area. Step parents can be listed in the ‘’Additional Contacts/Authorisations’ section if you wish.*   **Please inform Educators immediately of changes to this information**  **E.g. New address, telephone number/s, emergency contacts, or custody information.** | | | | | | | | | | | | | | |
| **INFORMATION ABOUT THE CHILD** | | | | | | | | | | | | | | |
| Child’s Given Name: | | | | Child’s Surname/Family Name: | | | | | | | | | | |
| Child’s Preferred Name: | | | | Child’s Date of Birth: / / | | | | | | | | | | |
| Gender: 🞏 Male 🞏 Female 🞏 Other | | | | Country of Birth: | | | | | | | | | | |
| Home Address: | | | | Suburb: | | | | | | | | | Postcode: | |
| Language(s) Spoken at Home: | | | | Child’s CRN Number: | | | | | | | | | | |
| Cultural Background: | | | | Expiry Date: | | | | | | | | | | |
| Is your child of Australian Aboriginal or Torres Strait Islander descent? *(Please tick one box only)* | | | | | | | | | | | | | | |
| 🞏 No | | | | | | | | | | | | | | |
| 🞏 Yes, Australian Aboriginal | | | | | | | | | | | | | | |
| 🞏 Yes, Torres Strait Islander | | | | | | | | | | | | | | |
| 🞏 Yes, both Australian Aboriginal and Torres Strait Islander | | | | | | | | | | | | | | |
| Please indicate if any of the following are applicable | | | | | | | | | | | | | | |
| 🞏 DHHS Involvement | | | | | | | | | | | | | | |
| 🞏 Child Protection involvement | | | | | | | | | | | | | | |
| 🞏 Child living in Out of Home Care (OOHS): Foster care / permanent care / kinship care *(please circle)* | | | | | | | | | | | | | | |
| **Evidence of your child’s date of birth is required.**  **Please provide a copy of your Child’s Birth Certificate.**  Or for non-Australian born children, please provide a travel document, which must indicate your child’s date of birth and the name of the parent(s)/guardian(s). | | | | | | | | | | | | | | |
| ***Staff use only:***  Evidence of child’s date of birth record has been received by an Educator | | | | | | | | | | | | | | |
| Educator Name: | | | | | | | | | | | | | | |
| Signature: | | | | | | | | | | | | | | |
| Date: / / | | | | | | | | | | | | | | |
| **INFORMATION ABOUT THE CHILD’S PARENTS OR GUARDIANS** | | | | | | | | | | | | | | |
| **Parent / Legal Guardian 1:** | | | | **Parent / Legal Guardian 2:** | | | | | | | | | | |
| Title: Mr / Mrs / Ms / Miss / Dr / Other (*please circle)*  If other, please specify: | | | | Title: Mr / Mrs / Ms / Miss / Dr / Other (*please circle)*  If other, please specify: | | | | | | | | | | |
| Given Name: | | | | Given Name: | | | | | | | | | | |
| Middle Name: | | | | Middle Name: | | | | | | | | | | |
| Surname/Family Name: | | | | Surname/Family Name: | | | | | | | | | | |
| Preferred Name: *(optional)* | | | | Preferred Name: *(optional)* | | | | | | | | | | |
| Parent 1 CRN Number: | | | | Parent 2 CRN Number: | | | | | | | | | | |
| Expiry: | | | | Expiry: | | | | | | | | | | |
| Does the child live with this parent/guardian?  🞏 Yes 🞏 No | | | | Does the child live with this parent/guardian?  🞏 Yes 🞏 No | | | | | | | | | | |
| Date of Birth: / / | | | | Date of Birth: / / | | | | | | | | | | |
| Gender: 🞏 Male 🞏 Female 🞏 Other | | | | Gender: 🞏 Male 🞏 Female 🞏 Other | | | | | | | | | | |
| Relationship to child: | | | | Relationship to child: | | | | | | | | | | |
| Country of Birth: | | | | Country of Birth: | | | | | | | | | | |
| Cultural Background: | | | | Cultural Background: | | | | | | | | | | |
| Language spoken at home: | | | | Language spoken at home: | | | | | | | | | | |
| Interpreter Required: 🞏 Yes 🞏 No | | | | Interpreter Required: 🞏 Yes 🞏 No | | | | | | | | | | |
| Address: *(If same as child, please tick* 🞏*)* | | | | Address: *(If same as child, please tick* 🞏*)* | | | | | | | | | | |
| Suburb: | Postcode: | | | Suburb: | | | | | | | Postcode: | | | |
| Postal Address: *(if different from above)* | | | | Postal Address: *(if different from above)* | | | | | | | | | | |
| Suburb: | Postcode: | | | Suburb: | | | | | | | Postcode: | | | |
| Telephone: Home: | | | | Telephone: Home: | | | | | | | | | | |
| Work: | | | | Work: | | | | | | | | | | |
| Mobile: | | | | Mobile: | | | | | | | | | | |
| Email: | | | | Email: | | | | | | | | | | |
| Are you of Australian Aboriginal or Torres Strait Islander descent? *(Please tick one box only)* | | | | Are you of Australian Aboriginal or Torres Strait Islander descent? *(Please tick one box only)* | | | | | | | | | | |
| 🞏 No | | | | 🞏 No | | | | | | | | | | |
| 🞏 Yes, Australian Aboriginal | | | | 🞏 Yes, Australian Aboriginal | | | | | | | | | | |
| 🞏 Yes, Torres Strait Islander | | | | 🞏 Yes, Torres Strait Islander | | | | | | | | | | |
| 🞏 Yes, both Australian Aboriginal and Torres Strait Islander | | | | 🞏 Yes, both Australian Aboriginal and Torres Strait Islander | | | | | | | | | | |
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| **OTHER HOUSEHOLD MEMBERS:** | | | | | | | | | | | | | | |
| Sibling’s Name: | | | | Age: | | | | | Gender 🞏 Male 🞏 Female 🞏 Other | | | | | |
| Sibling’s Name: | | | | Age: | | | | | Gender 🞏 Male 🞏 Female 🞏 Other | | | | | |
| Sibling’s Name: | | | | Age: | | | | | Gender 🞏 Male 🞏 Female 🞏 Other | | | | | |
| Are there any other people living in the child’s home? | | | | | | | | | | | | | | |
| Name: | | | | | | | Relationship to child: | | | | | | | |
| Name: | | | | | | | Relationship to child: | | | | | | | |
| **ADDITIONAL CONTACTS/AUTHORISATIONS:** | | | | | | | | | | | | | | |
| **Contact Person 1:** | | | | **Contact Person 2:** | | | | | | | | | | |
| Relationship to Child: | | | | Relationship to Child: | | | | | | | | | | |
| First Name: | | | | First Name: | | | | | | | | | | |
| Surname: | | | | Surname: | | | | | | | | | | |
| Address: | | | | Address: | | | | | | | | | | |
| Suburb: | | | | Suburb: | | | | | | | | | | |
| Postcode: | | | | Postcode: | | | | | | | | | | |
| Telephone: Home: | | | | Telephone: Home: | | | | | | | | | | |
| Work: | | | | Work: | | | | | | | | | | |
| Mobile: | | | | Mobile: | | | | | | | | | | |
| **The above person has my permission to:** *(Please tick)* | | | | **The above person has my permission to:** *(Please tick)* | | | | | | | | | | |
| **🞏** Collect the child from the service (Authorised Nominee) | | | | **🞏** Collect the child from the service (Authorised Nominee) | | | | | | | | | | |
| **🞏** Be notified of an emergency involving the child if any parent/guardian cannot be immediately contacted | | | | **🞏** Be notified of an emergency involving the child if any parent/guardian cannot be immediately contacted | | | | | | | | | | |
| **🞏** Consent to medical treatment or administration of medication for the child from a registered medical practitioner, hospital or ambulance service | | | | **🞏** Consent to medical treatment or administration of medication for the child from a registered medical practitioner, hospital or ambulance service | | | | | | | | | | |
| **🞏**  Consent to the transportation of the child by an ambulance service | | | | **🞏**  Consent to the transportation of the child by an ambulance service | | | | | | | | | | |
| **🞏** Consent to sign Incident, Injury Trauma Records and Medication Records | | | | **🞏** Consent to sign Incident, Injury Trauma Records and Medication Records | | | | | | | | | | |
| **🞏** Authorise an Educator to take the child outside of the education and care service premises | | | | **🞏** Authorise an Educator to take the child outside of the education and care service premises | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Contact Person 3:** | | | | **Contact Person 4:** | | | | | | | | | | |
| Relationship to Child: | | | | Relationship to Child: | | | | | | | | | | |
| First Name: | | | | First Name: | | | | | | | | | | |
| Surname: | | | | Surname: | | | | | | | | | | |
| Address: | | | | Address: | | | | | | | | | | |
| Suburb: | | | | Suburb: | | | | | | | | | | |
| Postcode: | | | | Postcode: | | | | | | | | | | |
| Telephone: Home: | | | | Telephone: Home: | | | | | | | | | | |
| Work: | | | | Work: | | | | | | | | | | |
| Mobile: | | | | Mobile: | | | | | | | | | | |
| **The above person has my permission to:** *(Please tick)* | | | | **The above person has my permission to:** *(Please tick)* | | | | | | | | | | |
| **🞏** Collect the child from the service (Authorised Nominee) | | | | **🞏** Collect the child from the service (Authorised Nominee) | | | | | | | | | | |
| **🞏** Be notified of an emergency involving the child if any parent/guardian cannot be immediately contacted | | | | **🞏** Be notified of an emergency involving the child if any parent/guardian cannot be immediately contacted | | | | | | | | | | |
| **🞏** Consent to medical treatment or administration of medication for the child from a registered medical practitioner, hospital or ambulance service | | | | **🞏** Consent to medical treatment or administration of medication for the child from a registered medical practitioner, hospital or ambulance service | | | | | | | | | | |
| **🞏**  Consent to the transportation of the child by an ambulance service | | | | **🞏**  Consent to the transportation of the child by an ambulance service | | | | | | | | | | |
| **🞏** Consent to sign Incident, Injury Trauma Records and Medication Records | | | | **🞏** Consent to sign Incident, Injury Trauma Records and Medication Records | | | | | | | | | | |
| **🞏** Authorise an Educator to take the child outside of the education and care service premises | | | | **🞏** Authorise an Educator to take the child outside of the education and care service premises | | | | | | | | | | |
| **AUTHORISATION:** | | | | | | | | | | | | | | |
| I ………………………………………………………………………………………………………………… (print parent/guardian’s name) | | | | | | | | | | | | | | |
| Parent of …………………………………………………………………………………………………… (child’s full name) | | | | | | | | | | | | | | |
| Authorise the Approved Provider, Nominated Supervisor or an Educator to: | | | | | | | | | | | | | | |
| 1. Seek medical treatment for my child from a registered medical practitioner, hospital or ambulance service and 2. Seek transportation of my child by an ambulance service. 3. Take the child outside of the education and care services for emergency evacuation drills. | | | | | | | | | | | | | | |
| Parent/Guardian Signature: | | | | | | Date: / / | | | | | | | | |
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| **CHILD’S IMMUNISATION INFORMATION:** | | | | | | | | | | | | | | |
| Under the ‘No Jab, No Play’ legislation all families seeking to enrol their child at an early year’s services in Victoria will be required to provide evidence that their child is: | | | | | | | | | | | | | | |
| * Fully immunised for their age; **or** * Is on a recognised catch-up schedule if the child has fallen behind with their vaccinations; **or** * Has a medical reason not to be vaccinated (medical doctor exemption required) | | | | | | | | | | | | | | |
| **Has your child been immunised?** | | | 🞏 Yes 🞏 No | | | | | | | | | | | |
| **Is your child’s immunisation up to date?** | | | 🞏 Yes 🞏 No | | | | | | | | | | | |
| If **Yes**, please tick and attach one of the following: | | | | | | | | | | | | | | |
| 🞏 Immunisation History Statement from the Australian Childhood Immunisation Register (ACIR can be contacted on 1800 653 809) | | | | | | | | | | | | | | |
| 🞏 Immunisation Status Certificate signed by a Medical Practitioner or local immunisation service | | | | | | | | | | | | | | |
| **If No, please attach a copy of your child’s medical exemption signed by a Medical Practitioner.** | | | | | | | | | | | | | | |
| Name: | | | | | | Signature: | | | | | | | | |
| ***Staff use only:***  Child’s Health Record and immunisation record has been received by Educator | | | | | | | | | | | | | | |
| Educator Name: | | | | | | | | | | | | | | |
| Signature: | | | | | | | | | | | | | | |
| Date: / / | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **CHILD’S HEATH AND MEDICAL INFORMATION:** | | | | | | | | | | | | | | |
| Child’s Medical Practitioner/Doctor: | | | | | | | | | | | | | | |
| Medical Centre: | | | | | | | | | | | | | | |
| Address: | | | | Suburb: | | | | | | | | Postcode: | | |
| Telephone Number: | | | | | | | | | | | | | | |
| Child’s Medicare Number: | | | | Expiry Date: | | | | | | | | | | |
| Ambulance subscription: 🞏 Yes 🞏 No | | | | Ambulance Membership Number: | | | | | | | | | | |
| Health Fund: 🞏 Yes 🞏 No | | Provider Name: | | | | | | Membership Number: | | | | | | |
| Maternal & Child Health (MCH) Centre: | | | | Maternal & Child Health (MCH) Nurse: | | | | | | | | | | |
| Has your child had their 3½ year old assessment? 🞏 Yes | | | | | 🞏 No – please contact Maternal and Child Health on 9742 8148 for an appointment. | | | | | | | | | |
| **Please note –** If you tick **‘Yes’** to any of the following medical information, before your child can be left in the service, you are required to provide the service with an individual medical management plan for your child. The medical management plan must be signed by the medical practitioner who is treating your child. | | | | | | | | | | | | | | |
| Has your child been diagnosed as being at risk of **anaphylaxis?** | | | | | | | | | | | | | | 🞏 Yes 🞏 No |
| If **Yes**, please provide details: | | | | | | | | | | | | | | |
| Has your child been prescribed an adrenaline auto-injector device? (AAID) | | | | | | | | | | | | | | 🞏 Yes 🞏 No |
| If **Yes**, please attach a copy of the Anaphylaxis Management Plan. | | | | | | | | | | | | | | |
| In the case of anaphylaxis, you will be provided with a copy of the service’s anaphylaxis management policy. More information is available at [www.education.vic.gov.au/school/teachers/health/pages/anaphylaxisschl.asp](http://www.education.vic.gov.au/school/teachers/health/pages/anaphylaxisschl.asp) | | | | | | | | | | | | | | |
| ***Staff use only:*** | | | | | | | | | | | | | | |
| Anaphylaxis Management Plan received: | | | | | | | | | | Date: / / | | | | |
|  | | | | | | | | | | | | | | |
| Does your child have any **allergies?** | | | | | | | | | | | | | | 🞏 Yes 🞏 No |
| If **Yes**, please provide details: | | | | | | | | | | | | | | |
| Has a risk minimisation/communication plan been completed by the service in consultation with you? | | | | | | | | | | | | | | 🞏 Yes 🞏 No |
| ***Staff use only:*** | | | | | | | | | | | | | | |
| Risk Minimisation/Communication Plan received: | | | | | | | | | | Date: / / | | | | |
|  | | | | | | | | | | | | | | |
| Has your child been diagnosed with **asthma?** | | | | | | | | | | | | | | 🞏 Yes 🞏 No |
| If **Yes**, please attach a copy of the Asthma Management Plan. | | | | | | | | | | | | | | |
| ***Staff use only:*** | | | | | | | | | | | | | | |
| Asthma Management Plan received: | | | | | | | | | | Date: / / | | | | |
|  | | | | | | | | | | | | | | |
| Has your child been diagnosed with **diabetes?** | | | | | | | | | | | | | | 🞏 Yes 🞏 No |
| If **Yes**, please attach a copy of the Diabetes Management Plan | | | | | | | | | | | | | | |
| ***Staff use only:*** | | | | | | | | | | | | | | |
| Diabetes Management Plan received: | | | | | | | | | | Date: / / | | | | |
|  | | | | | | | | | | | | | |  |
| Has your child been diagnosed with **epilepsy?** | | | | | | | | | | | | | | 🞏 Yes 🞏 No |
| If **Yes**, please attach a copy of the Epileptic Action Plan. | | | | | | | | | | | | | | |
| ***Staff use only:*** | | | | | | | | | | | | | | |
| Epileptic Management Plan received: | | | | | | | | | | Date: / / | | | | |
| **CHILD’S HEATH AND MEDICAL INFORMATION:** | | | | | | | | | | | | | | |
| Does your child have any **medical conditions/diagnosed healthcare needs? (Not listed above)** | | | | | | | | | | | | | | 🞏 Yes 🞏 No |
| If **Yes**, please provide details: | | | | | | | | | | | | | | |
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| If **Yes**, please attach a copy of the Medical Management Plan/Risk Minimisation Plan | | | | | | | | | | | | | | |
| ***Staff use only:*** | | | | | | | | | | | | | | |
| Medical Conditions Management Plan/Rick Minimisation Plan received: | | | | | | | | | | Date: / / | | | | |

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| **CHILD’S HEATH AND MEDICAL INFORMATION - CONTINUED:** | | | |
| I agree, for my child’s wellbeing, for Educators to display my child’s asthma and/or allergy triggers, food restrictions and/or medical alert in the service. | | | 🞏 Yes 🞏 No |
| I agree, for my child’s wellbeing, for Educators to display my child’s medical management plan on the wall within the service. | | | 🞏 Yes 🞏 No |
| I agree for a photo of my child to be displayed on their anaphylaxis or allergy action plan/asthma action plan/medical management plan in the service. | | | 🞏 Yes 🞏 No |
|  | | | |
| **DIETARY RESTRICTIONS/RELIGIOUS OR CULTURAL REQUIREMENTS:** | | | |
| Does your child have any **dietary restrictions?** | | 🞏 Yes 🞏 No | |
| Please list details: | | | |
|  | | | |
|  | | | |
| Does your child have any **religious requirements?** | | 🞏 Yes 🞏 No | |
| Please list details: | | | |
|  | | | |
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| Does your child have any **cultural requirements?** | | 🞏 Yes 🞏 No | |
| Please list details: | | | |
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| **Food Tasting / Cooking Activities** | | | |
| I acknowledge that food tasting and cooking are valid opportunities for my child to learn and that staff may provide these experiences to my child during the year. I understand that staff will adhere to allergy, cultural and dietary needs of my child when food is offered within the program. | | | 🞏 Yes 🞏 No |
| I give permission for my child to participate in food preparation and cooking and as a part of the program, to eat food not provided by me, whilst at the service. | | | 🞏 Yes 🞏 No |
|  | | | |
| **CHILD’S HEALTH AND DEVELOPMENT INFORMATION: - OPTIONAL** | | | |
| Please list other agencies your child is linked to e.g. Paediatrician, Early Childhood Intervention Service, Therapist, Early Years Consultant, Inclusion Professionals or other: | | | |
| Contact Name 1: | Phone Number: | | |
| Agency / Service Type: | | | |
| Contact Name 2: | Phone Number: | | |
| Agency / Service Type: | | | |
| Do you authorise the Educator to communicate with the contact(s) listed to support your child’s development, health and wellbeing? | | 🞏 Yes 🞏 No | |
| Do you have any concerns regarding your child’s development? | | 🞏 Yes 🞏 No | |
| Do you believe your child may need additional support or guidance to participate fully in the program? | | 🞏 Yes 🞏 No | |
| If you have answered **Yes** to any of the questions above, please provide details to assist educators to maximise your child’s participation in the program: | | | |
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| **SUNSCREEN APPLICATION:** | | | |
| Please refer **to Wyndham City’s Early Education and Care Services Sun Smart Procedure** *(available from staff upon request)* | | | |
| The use of sun hats and sunscreen is encouraged at all times. As per the Early Education and Care Services Sun Smart Procedure, you are required to provide your child with an appropriate wide brimmed hat or legionnaire hat with a back flap to wear during outdoor activity from September through to April and to apply 30+ (or higher), broad spectrum, water-resistant sunscreen before they arrive at the service. | | | |
| In order to comply with the Sun Smart Procedure, the Educator will apply 30+ (or higher), broad spectrum, water-resistant sunscreen to your child as required. | | | |
| Does your child have a sensitivity to sunscreen? | | 🞏 Yes 🞏 No | |
| If **Yes**, I agree to provide a suitable product (with my child’s name and in original packaging) and within the use-by date, to be stored appropriately by Educators and applied by Educators as per the Wyndham City Early Education and Care Services Sun Smart Procedure. | | | |
| Parent/Guardian Signature: | Date: / / | | |
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| **COURT ORDERS, PARENT ORDERS OR PARENTING PLANS RELATING TO YOUR CHILD:** | | | |
| *A* ***Parenting Order*** *means a parenting order within the meaning of Section 64B(1) of the Family Law Act 1975 (Commonwealth)*  *A* ***Parenting Plan*** *means a Parenting Plan within the meaning of Section 63C(1) of the Family Law Act 1975 (Commonwealth), and includes a registered parenting plan within the meaning of section 63C(6) of that Act.* | | | |
| 1. Are there any court orders, parenting orders or parenting plans relating to the powers, duties and responsibilities or authorisations of any person in relation to the child or access to the child? | | 🞏 No – go to part (b)  🞏 **Yes, please attach a copy** | |
| 1. Are there any court orders relating to the child’s residence or the child’s contact with a parent or other person? | | 🞏 No  🞏 **Yes, please attach a copy** | |
| ***Staff use only:*** | | | |
| Court Order/ other documents have been received by Staff/Educator | | | |
| Educator Name: | | | |
| Signature: | | | |
| Date: / / | | | |
|  | | | |
| **DIGITAL MEDIA:** | | | |
| Are you willing to have photos taken of your child for use in the following publications and other editorial material? Please tick which media are permitted: | | | |
| 1. Major Publications (Quality Community Plan, Annual Report, Community Directory, Wyndham News) | | | 🞏 Yes 🞏 No |
| 1. Council brochures, newsletters and PowerPoint presentations | | | 🞏 Yes 🞏 No |
| 1. Council web site | | | 🞏 Yes 🞏 No |
| 1. Newspapers | | | 🞏 Yes 🞏 No |
| 1. Newsletters, noticeboards, with the service foyer and wall displays | | | 🞏 Yes 🞏 No |
| I understand that if I wish to take photos of other children at the service, I must obtain consent from the child’s parent or guardian before doing so. | | | 🞏 Yes 🞏 No |
| I understand that during the year, parents’ guardians are invited to attend functions (birthdays, Christmas, parent/guardian nights) where they may take video footage or photos of children. I understand and agree that if I do not want my child included in such footage, I will need to make prior arrangements with Educators. | | | 🞏 Yes 🞏 No |
| I understand that if the service produces a video, Educators will inform me of the purpose, use and circulation of the footage, prior to seeking my permission for my child to be included. | | | 🞏 Yes 🞏 No |

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| **OTHER INFORMATION:** | | |
| **Room Displays:** | | |
| I agree for my child’s name, birth date and photo to be displayed in the service. (This includes a display showing each child’s birthday and group lists stating which locker/bag and/or towel hook my child may have). | | 🞏 Yes 🞏 No |
| I agree for my name to be displayed in the service  e.g. on parent help duty rosters. | | 🞏 Yes 🞏 No |
| **Permission to Release Information to Agencies and other external authorities:** | | |
| I give permission for the Early childhood Educators to release my child’s reports and records and/or speak to other agencies e.g. Medical Practitioner, Early Childhood Specialists or my child’s potential Kindergarten teachers, regarding my child’s progress. I understand the Educator will inform me before releasing any information. | | 🞏 Yes 🞏 No |
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| **PRIVACY NOTIFICATION:** | | |
| Wyndham City Council is bound by the *Privacy and Data Protection Act* 2014 and the *Health Records Act* 2001. Your consent is required for the collection and use of your personal and/or health information and that of your child. The personal and health information requested on this form is being collected by Council for the purpose of planning and delivering proper health and developmental care and education services to your child while obtaining and/or attending Wyndham services (which includes MCH, Kindergarten, PFSO Services). The information will be used by Council and it may be shared with Educators, early intervention, health and welfare service providers for the purposes mentioned. Your information will be stored in Council’s Customer Database and used to identify you when communicating with Council and for Council to deliver services and information to you. The information will only be disclosed to other persons or agencies if consented to by both parents; or the authorised parent/guardian; or as permitted by law. For further information on how your personal and health information will be handled, see Council’s Privacy Policy on its website. Authorised parents and guardians may apply for access and/or amendment of the information. Requests for access and/or amendment of the information should be made in writing to Council’s Privacy Officer.  ***Please Note:*** Any documented proof of living, working, studying or using childcare in Wyndham is required to confirm your priority level when allocating places. If a copy is provided to Council, that document will be securely destroyed once sighted. | | |
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| **DECLARATION:** | | |
| *I/We declare that information contained in this enrolment record is true and correct and undertake to immediately inform Early Education and Care Services in the event of any change to the information.*  *I/We have read and accept that I/we will agree to abide by the Wyndham City’s Early Education and Care Services Policy and Procedures and their implementation, which is available from staff upon request.*  *I/We agree that I/we will reimburse any expenses incurred by Wyndham City following emergency medical treatment received by my child.*  *I/We consent to the collection and use of personal and health information on this form as outlined above in Privacy Notification.*  *I/We understand that I/we may at any time withdraw the permission given, after consultation with the Early Childhood Educators and may apply for access or amendment to the information through Council’s Privacy Officer.* | | |
| **Parent / Legal Guardian 1 Name:** | | |
| Signature: | Date: / / | |
| **Parent / Legal Guardian 2 Name:** | | |
| Signature: | Date: / / | |