

A Guardian includes parent of the child and/or a person with parental responsibilities for the child under a decision or court order. Parental responsibility is a term defined under section 61C of the Family Law Act 1975, which means all the duties, powers, responsibilities and authority which, by law, parents have in relation to children.

Parents/Guardian Information 1

First Name:	Middle Name:
Last Name:	Known as (Preferred Name):
Date of Birth: / /	Relationship to Child:
CRN:	
Is this a primary guardian ? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Contact Details

Email Address:	Mobile Number:	
Home Number:	Work Number:	
Address:		
Suburb:	State:	Postcode:

Cultural Details

Aboriginal or Torres Strait Islander Background:	Nationality:
Cultural Background:	Languages Spoken:
Religion:	

Education and Occupation Details

Are you currently self employed studying or working? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employment Status:	Job Title/Occupation:	
Employer/Organisation Name:		
Employer/Organisation Address:		
Suburb:	State:	Postcode:

Authorisation

This guardian is authorised to:

authorise the service to seek medical treatment from a registered medical practitioner hospital or ambulance service, including transportation of the child(ren) by an ambulance service

authorise the service to administer medication to the child(ren).

authorise the service to take the child(ren) outside the service on excursions or outings, with the service's educators.

be contacted in an emergency concerning the child(ren).

drop off/pick up the child(ren) to/from the service.

access information of the child(ren) via Xap Guardian Portal or Xap Smile App

A Guardian includes parent of the child and/or a person with parental responsibilities for the child under a decision or court order. Parental responsibility is a term defined under section 61C of the Family Law Act 1975, which means all the duties, powers, responsibilities and authority which, by law, parents have in relation to children.

Parents/Guardian Information 2

First Name:

Middle Name:

Last Name:

Known as (Preferred Name):

Date of Birth: / /

Relationship to Child:

CRN:

Is this a primary guardian ?

Yes No

Contact Details

Email Address:

Mobile Number:

Home Number:

Work Number:

Address:

Suburb:

State:

Postcode:

Cultural Details

Aboriginal or Torres Strait Islander Background:

Nationality:

Cultural Background:

Languages Spoken:

Religion:

Education and Occupation Details

Are you currently self employed studying or working?

Yes No

Employment Status:

Job Title/Occupation:

Employer/Organisation Name:

Employer/Organisation Address:

Suburb:

State:

Postcode:

Authorisation

This guardian is authorised to:

authorise the service to seek medical treatment from a registered medical practitioner hospital or ambulance service, including transportation of the child(ren) by an ambulance service

authorise the service to administer medication to the child(ren).

authorise the service to take the child(ren) outside the service on excursions or outings, with the service's educators.

be contacted in an emergency concerning the child(ren).

drop off/pick up the child(ren) to/from the service.

access information of the child(ren) via Xap Guardian Portal or Xap Smile App

In case of an emergency, service staff will contact guardians initially. If contact is unsuccessful, the nominees will be contacted as per the authorisations and the contact priority set for them. An authorised nominee is defined under section 170 of national laws as a person who is authorised by guardians to collect the child from service.

Nominee Information 1

First Name:

Middle Name:

Last Name:

Relationship to child:

Email:

Mobile Number:

Address:

Suburb:

State:

Postcode:

Authorisation

This person is authorised to:

- authorise the service to seek medical treatment from a registered medical practitioner hospital or ambulance service, including transportation of the child(ren) by an ambulance service
- authorise the service to administer medication to the child(ren).
- authorise the service to take the child(ren) outside the service on excursions or outings, with the service's educators.
- be contacted in an emergency concerning the child(ren).
- drop off/pick up the child(ren) to/from the service.
- authorise my child to be transported by the service or on transportation arranged by the service

In case of an emergency, service staff will contact guardians initially. If contact is unsuccessful, the nominees will be contacted as per the authorisations and the contact priority set for them. An authorised nominee is defined under section 170 of national laws as a person who is authorised by guardians to collect the child from service.

Nominee Information 2

First Name:

Middle Name:

Last Name:

Relationship to child:

Email:

Mobile Number:

Address:

Suburb:

State:

Postcode:

Authorisation

This person is authorised to:

- authorise the service to seek medical treatment from a registered medical practitioner hospital or ambulance service, including transportation of the child(ren) by an ambulance service
- authorise the service to administer medication to the child(ren).
- authorise the service to take the child(ren) outside the service on excursions or outings, with the service's educators.
- be contacted in an emergency concerning the child(ren).
- drop off/pick up the child(ren) to/from the service.
- authorise my child to be transported by the service or on transportation arranged by the service

In case of an emergency, service staff will contact guardians initially. If contact is unsuccessful, the nominees will be contacted as per the authorisations and the contact priority set for them. An authorised nominee is defined under section 170 of national laws as a person who is authorised by guardians to collect the child from service.

Nominee Information 3

First Name:

Middle Name:

Last Name:

Relationship to child:

Email:

Mobile Number:

Address:

Suburb:

State:

Postcode:

Authorisation

This person is authorised to:

- authorise the service to seek medical treatment from a registered medical practitioner hospital or ambulance service, including transportation of the child(ren) by an ambulance service
- authorise the service to administer medication to the child(ren).
- authorise the service to take the child(ren) outside the service on excursions or outings, with the service's educators.
- be contacted in an emergency concerning the child(ren).
- drop off/pick up the child(ren) to/from the service.
- authorise my child to be transported by the service or on transportation arranged by the service

In case of an emergency, service staff will contact guardians initially. If contact is unsuccessful, the nominees will be contacted as per the authorisations and the contact priority set for them. An authorised nominee is defined under section 170 of national laws as a person who is authorised by guardians to collect the child from service.

Nominee Information 4

First Name:

Middle Name:

Last Name:

Relationship to child:

Email:

Mobile Number:

Address:

Suburb:

State:

Postcode:

Authorisation

This person is authorised to:

- authorise the service to seek medical treatment from a registered medical practitioner hospital or ambulance service, including transportation of the child(ren) by an ambulance service
- authorise the service to administer medication to the child(ren).
- authorise the service to take the child(ren) outside the service on excursions or outings, with the service's educators.
- be contacted in an emergency concerning the child(ren).
- drop off/pick up the child(ren) to/from the service.
- authorise my child to be transported by the service or on transportation arranged by the service

Child Information		
First Name:	Middle Name:	
Last Name:	Known as (Preferred Name):	
Date of Birth: / /	Gender:	
CRN:	Resides With:	
Address:		
Suburb:	State:	Postcode:
List all the child's favourite activities and interests:		
I give permissions for photos/videos to be used of my child for promotional material in line with the relevant policies. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Cultural Background of Child		
Aboriginal or Torres Strait Islander Background:	Country Of Birth:	
Nationality:	Cultural Background:	
Language Spoken:	Religion:	
School Details		
Is the child currently attending school? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Year Level:	Start Date: / /	
School Name:		
Child's Doctor and Insurance Information		
Medical Clinic Name:		
Doctor's Name:		
Clinic/Doctor's Contact No.:		
Medical Clinic Address:		
Suburb:	State:	Postcode:
Child's Medicare Number:	Medicare Expiry Date: / /	
Ambulance Subscription No:	Subscription Expiry Date: / /	
Private Health Insurance:	Insurance Membership No:	
Child's Health and Immunisation Information		
Has your child been immunised? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Immunisation Record:		
	Age	Disease
<input type="checkbox"/>	Birth	Hepatitis B
<input type="checkbox"/>	Two months (from six weeks)	Diphtheria, tetanus, pertussis, hepatitis B, polio, Haemophilus Influenzae type b (Hib)
		Pneumococcal
		Rotavirus


<input type="checkbox"/>	Four months	Diphtheria, tetanus, pertussis, hepatitis B, polio, Haemophilus Influenzae type b (Hib)
		Pneumococcal
		Rotavirus
<input type="checkbox"/>	Six months	Diphtheria, tetanus, pertussis, hepatitis B, polio, Haemophilus Influenzae type b (Hib)
<input type="checkbox"/>	12 months	Measles, mumps, rubella (MMR)
		Meningococcal ACWY
		Pneumococcal
<input type="checkbox"/>	18 months	Measles, mumps, rubella, varicella (chickenpox) (MMRV)
		Diphtheria, tetanus, pertussis
		Haemophilus Influenzae type b (Hib)
<input type="checkbox"/>	Four years	Diphtheria, tetanus, pertussis (whooping cough), polio
<input type="checkbox"/>	Six months of age to less than five years of age (from may 2018)	Influenza

Supporting Document type:

Please attach the photo copy of following documents type with this application. (if applicable)

 Copy of the supporting document

Please attach the photo copy of following documents type with this application. (if applicable)

 Copy of medical exemption from registered medical practitioner

Has the child been diagnosed with any of the following health conditions?:


Anaphylaxis

Yes No

Does an Anaphylaxis management plan, signed by a doctor, exist for the child?

Yes No

Please attach the photo copy of following documents type with this application. (if applicable)


 Copy of anaphylaxis management plan

Exp. Date of management plan: / /

Has an Anaphylaxis Risk minimisation and communication plan been completed in consultation with the service/educator?

Yes No

Please attach the photo copy of following documents type with this application. (if applicable)

 If Yes, please upload a copy of the plan below

EpiPen/Anapen Expiry Date: / /

Anaphylaxis Triggers:

Medication Name:

Expiry Date of Medication:


Asthma

Yes No

Does an Asthma management plan, signed by a doctor, exist for the child?

Yes No


Please attach the photo copy of following documents type with this application. (if applicable)

 Copy of asthma management plan

Exp. Date of management plan: / /

Has an Asthma Risk minimisation and communication plan been completed in consultation with the service/educator? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please attach the photo copy of following documents type with this application. (if applicable) 📎 If Yes, please upload a copy of the plan below	
Asthma Triggers:	
Asthma Medication <i>Ventolin or another asthma treatment must be provided to the centre. This medication must remain at the centre at all times in a clearly labelled plastic bag.</i>	
Medication Name:	Expiry Date of Medication:
Allergy <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does an Allergy management plan, signed by a doctor, exist for the child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please attach the photo copy of following documents type with this application. (if applicable) 📎 Copy of allergy management plan	
Expiry Date of Plan: / /	
Has an Allergy Risk minimisation and communication plan been completed in consultation with the service/educator? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please attach the photo copy of following documents type with this application. (if applicable) 📎 If Yes, please upload a copy of the plan below	
Allergy Medication <i>Medication must be provided to the centre. This medication must remain at the centre at all times in a clearly labelled plastic bag.</i>	
Allergy Triggers:	
Medication Name:	Expiry Date of Medication:
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does a Diabetes management plan, signed by a doctor, exist for the child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please attach the photo copy of following documents type with this application. (if applicable) 📎 Copy of diabetes management plan	
Expiry Date of Plan: / /	
Has a Diabetes Risk minimisation and communication plan been completed in consultation with the service/educator? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please attach the photo copy of following documents type with this application. (if applicable) 📎 If Yes, please upload a copy of the plan below	
Diabetes Medication	
Medication Name:	Expiry Date of Medication:
Will the child require medication (other than indicated above) whilst attending the service? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Medication	
Medication Name:	Expiry Date of Medication:
Does the child have any dietary requirements <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please specify the dietary restrictions:	

Please attach the photo copy of following documents type with this application. (if applicable)


 Supporting Document

Does the child have a diagnosed disability?

Yes No

If yes, please specify the diagnosed disability:

Please attach the photo copy of following documents type with this application. (if applicable)

 Copy of the supporting document


Is the child accessing any specialist services or on a waiting list for such services?

Yes No

Specialist Service(s):

More Details on Specialist Services:

Please attach the photo copy of following documents type with this application. (if applicable)


 Copy of the supporting document

Does the child have any other additional needs?

Yes No

If yes, please specify the other additional needs:

Please attach the photo copy of following documents type with this application. (if applicable)

 Copy of the supporting document

Is the child currently in an out of home care arrangement (including kinship care)?

Yes No


If yes, please specify the out of home care arrangement:

Does the parent/guardian have any specific conditions that make it difficult to get the child to child care? (e.g. a disability or medical condition)

Yes No

If yes, please specify the specific condition:

Please attach the photo copy of following documents type with this application. (if applicable)

 Copy of the supporting document

Guardian Consent

Sunscreen Authorisation:

Authority for service staff to administer sunscreen:

Parent/Guardian gives permission for service staff members to apply a suitable sunscreen to the child.

Child is sensitive/allergic to some sunscreen brands. Parent/Guardian will provide a suitable sunscreen brand for the child and gives permission for service staff members to apply this sunscreen.

Sunscreen that is provided by you for your child must be placed in a sealed container clearly labelled with your child's name.

Preferred sunscreen brand:

Photographs and Publicity:

Does the parent/guardian give permission for the child's name and photographs to be used in the service (service display's)?

Yes No

Does the parent/guardian give permission for the child's name and photographs to be used for the service's promotional events including media?

Yes No

Does the parent/guardian give permission for the child's name and photographs to be included in group posts that are distributed to the service's other guardians?

Yes No

Insect Repellant

Yes No

Court Appointed Orders

Are there any court/parenting/intervention orders or parenting plans relating to this child? Yes No

Summary of the court/parenting/intervention order or parenting plan:

Please attach the photo copy of following documents type with this application. (if applicable)

 Copy of the court/parenting/intervention or parenting plan

Expiry Date of Order/Plan: / /

Person to whom the order relates:

Authorised Contact for this early years enrolment:

We offer a credit/debit card or bank direct debit facility. Payments are processed electronically through a secure payment provider, Quickpay.

Direct Debit Authority

Bank Account

BSB:

Account Number:

Account Name:

OR

Credit Card

Card Holder Name:

Card Number:

Expiry Date: / /

CVV:

- By providing the following details, I authorize Quickpay (the payment gateway provider) to debit payments from the credit card or bank account nominated below at intervals and amounts as per the payment Terms and Conditions.
- I authorise Quickpay Pty Ltd ABN 62 649 941 997, acting on behalf of the Big Childcare - Aintree PS OSHC to debit payments from my specified bank account/credit card above, and I acknowledge that Quickpay will appear on my bank account/credit card statement.
- By ticking this box, I also agree that I have read and accept the Quickpay Terms and Conditions.

Declaration

As the person with lawful authority for the child or children referred to on this enrolment form:

I _____, declare that the information in this enrolment form is true and correct and immediately inform the child care centre in the event of any change to this information. I also make the following declarations:

- I agree that all the information I have provided in this enrolment form is true and correct.
- I am a person with lawful authority over the child(ren) referred to in this application.
- I agree to collect or make an arrangement for the collection of the child referred to in this enrolment form if the child becomes unwell at the service.
- I allow service staff or management to seek and authorise any medical treatment from a medical practitioner and/or arrange ambulance transportation for the child to a hospital in case of emergency. I also take liability for all expenses that may arise.
- I agree to inform the service of all medical needs and requirements of my child. This includes relevant documentation, medication and authorisation to follow the medical plan/administer medication. I will ensure the medication my child may need is provided to Big Childcare before my child attends and that the medication is within date.
- I agree that the ongoing management of the child's medical condition, if any, remains my sole responsibility and is not, and in no circumstances becomes, the obligation of the service staff or management. I acknowledge that I will need to provide Big Childcare a current copy of my child's medical management plans before they can attend.
- I agree that in the event of any adverse reaction by the child to the administration of medication which I have authorised or in the event that any action or inaction on the part of the service staff or management results in any aggravation, exacerbation, acceleration or deterioration of any medical condition suffered by the child, I release the service, its staff, management and other relevant personnel and their respective assignees and insurers from all actions, suits and claims of any nature, I or my child may have relating to the administration of medication or the failure to administer or any action or failure to act related to any medication condition identified in the child's action/management plan.
- I agree to inform the service if my child contracts any illness which could be detrimental to the health of others at the service. I acknowledge that my child may not be able to attend if they are suffering from an infectious or communicable disease.
- I accept full responsibility for my child's belongings when they are attending the service and understand that Big Childcare is not liable for personal injury, property damage or loss sustained by any participant or visitor in a Big Childcare program.
- I understand that if my child continuously demonstrates inappropriate or unacceptable behaviour, I may be called to collect them. In the case of serious displays of inappropriate or unacceptable behaviour I will be notified and my child may be removed or suspended for a period of time. Should support mechanisms and procedures be implemented and followed and patterns of unacceptable or inappropriate behaviours continue to be identified I understand that my child may be excluded permanently from the service.
- I acknowledge that there may be a time when my child's full name will be displayed at the service. If I have any concerns about this, I will advise in writing.
- I agree to pay all fees as communicated by service this includes but is not limited to non-communication and late fees. I acknowledge that casual bookings may incur an additional fee and understand that the fees are displayed in each service.
- I agree to the Terms and Conditions and Privacy Policy of the service.
- I agree to the Terms & Conditions and Privacy Policy of Xap Technologies Pty Ltd.

I understand that Big Childcare Policy and Procedures and our Parent Code of Conduct are available to view on our website.

In the event of overdue fees, I agree that my account may be suspended until full payment is made in accordance with the relevant policies. I understand that I am responsible for any cost involved with the recovery of debt and any further action required.

I understand that I am responsible for providing the correct Child Care Subsidy (CCS) information to Big Childcare and Centrelink.

The service reserves the right to change terms and conditions at any time.

Days/Program	
CentreName:	
BookingType: <input type="checkbox"/> Permanent <input type="checkbox"/> Casual	<i>(Please complete the program details, if you are requestng permanent care for the child.)</i>
Program 1	
Program Name (Please select only one from the available programs)	
Booking Start Date(dd/mm/yyyy):	Booking End Date(dd/mm/yyyy):
Preffered Days (Please select from the available days in the program):	
<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	
<input type="checkbox"/> I am flexible with days <input type="checkbox"/> I can accept less days	
Program 2	
Program Name (Please select only one from the available programs)	
Booking Start Date(dd/mm/yyyy):	Booking End Date(dd/mm/yyyy):
Preffered Days (Please select from the available days in the program):	
<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	
<input type="checkbox"/> I am flexible with days <input type="checkbox"/> I can accept less days	

Office/Educator Use Only	
Has a communication plan been developed to ensure staff and volunteers are informed about:	
The medical conditions policy	<input type="checkbox"/> Yes <input type="checkbox"/> No
The medical management plan	<input type="checkbox"/> Yes <input type="checkbox"/> No
The risk minimisation plan for the child	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the child's parent/guardian endorsed the medical management plan and risk minimisation plan for the child?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Educator Responsible:	Date Implemented: / /
Child's Health Documents (if applicable)	
Has your child been immunised?	
Copy of Immunisation History Statement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Copy of Immunisation Status Certificate	<input type="checkbox"/> Yes <input type="checkbox"/> No
Copy of medical exemption from registered medical practitioner	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child suffer from any of the following health conditions? (if applicable)	
Anaphylaxis	
Copy of anaphylaxis management plan	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please upload a copy of the plan below	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	
Copy of asthma management plan	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy	
Copy of allergy management plan	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	
Copy of diabetes management plan	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dietary Restrictions	
Supporting Document	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosed or Disability	
Copy of the supporting document	<input type="checkbox"/> Yes <input type="checkbox"/> No
Specialist Services	
Copy of the supporting document	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional Needs	
Copy of the supporting document	<input type="checkbox"/> Yes <input type="checkbox"/> No
Out of Home Care Arrangement	
Copy of the supporting document	<input type="checkbox"/> Yes <input type="checkbox"/> No