



## ADULTS AUTHORISED TO COLLECT YOUR CHILD

Please specify names of responsible adults authorised to collect your child (someone other than parents).

1. Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Ph No: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mob) \_\_\_\_\_

2. Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Ph No: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mob) \_\_\_\_\_

## SPECIAL CIRCUMSTANCES

Are there any court orders affecting the custody or access to your child? (Please provide documentation):  
\_\_\_\_\_

Is there any special requirements concerning your child? \_\_\_\_\_

Note: This may relate to your child's culture or religion or, if the child has a disability or other special needs.

Please detail: \_\_\_\_\_  
\_\_\_\_\_

## IMMUNISATION / MEDICAL HISTORY

Has your child been immunised: **YES / NO** (Please present documentation)

Does your child have any allergies? \_\_\_\_\_ If yes please list:

Does your child have any relevant medical history? (eg asthma, epilepsy) If yes, please provide a copy of your doctor's management plan. \_\_\_\_\_  
\_\_\_\_\_

## MEDICAL INFORMATION

Family Doctor: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Address: \_\_\_\_\_

Family Dentist: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Address: \_\_\_\_\_

### **Please read carefully before signing**

- I declare that all the above information is correct.
- I authorise the staff to call the Ambulance or seek emergency medical, dental or hospital treatment for my child in case of an accident or emergency.
- I give permission for the staff to administer the following items to my child for pain, fever, or if the body temperature is 38 degrees Celsius or higher, \_\_\_\_\_ Panadol, \_\_\_\_\_ bandaids, \_\_\_\_\_ sunscreen, baby wipes.
- I give my permission for the staff to take my child for walks to local parks, excursions or outside the Centre.
- I will give two weeks notice in writing before I withdraw my child from the centre or reduce the number of days attending or I will pay the full fees for two weeks in lieu of the notice.
- I declare that I have read the Centre's Information Book/policies and accept all responsibility to ensure all rules and fee payments are met.
- I will be liable for all costs incurred in debt collection if I do not pay my fees.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_ WITNESS: \_\_\_\_\_