Acacia Ridge Long Day Care & Kindergarten Waiting List

Childs name: (First name) _____(Surname) _____

Child Date of Birth: ___ ___/___ ___/___ ___ ___ ___

Child CRN: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Primary Parent/ Guardian Name:

(First Name) _____ (Surname) _____

Phone Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Parent CRN: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Parent Date of Birth: ___ ___/___ ___/___ ___ ___ ___

Address:

Email:

Days Requested

☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY

Start Date: ___ ___/___ ___/ ___ ___ ___ ___

Priority of Access

Our service has a priority of access guidelines. Please select which your family fits into

☐ **Priority One** –A child at risk of serious abuse or neglect.

☐ **Priority Two** – A child of a single parent who satisfies, or parents that both satisfy, the work/training/study test under section 14 of the Family Assistance Act. That is, working (including work as a carer) seeking employment, studying or training or on leave related to employment.

☐ **Priority Three** – Any other child. For example, a child who's parents have chosen to stay at home.

Priority will also be given to the following children

☐ Children in Aboriginal or Torres Strait Islander families

☐ Children in families which include a disabled person

☐ Children in families on lower incomes

☐ Children in families with a non-English speaking background

☐ Children in socially isolated families

☐ Children of single parents

Do you have a Health Care Card?

☐ Yes ☐ No

Agreement

I agree that the information provided on this form is a true and accurate reflection of my child's and family's need.

PARENT SIGNATURE: **Date:**

Thank you for your interest, we endeavor to offer you a position as soon as possible.

HEALTH / MEDICAL INFORMATION

To ensure we have the best supports possible in place for your child please provide us with the following information:

ASTHMA: If your child has been diagnosed with asthma, an Asthma Management Plan (Medical Management Plan) must be completed by your GP and attached to this form.

☐ YES Asthma Management plan attached

DIABETES: If your child has been diagnosed with diabetes, a Diabetes Management Plan (Medical Management Plan) must be completed by your GP and attached to this form.

☐ YES: A Diabetes Management plan is attached.

ANAPHYLAXIS: If your child has been diagnosed with anaphylaxis, an Anaphylaxis Management Plan (Medical Management Plan) must be completed by your GP and attached to this form.

☐ YES: An Anaphylaxis Management plan is attached.

ALLERGIES: Does your child suffer from any allergies (hayfever, insect bites, medications etc)

☐ YES: please give details including appropriate treatment: For food allergies please see next section

Has your child any physical disabilities: sight, hearing or speech that have been occurring for more than 6 months?

☐ Yes ☐ No If yes please provide details

Does your child regularly visit a specialist?

☐ Yes ☐ No If yes please provide details

Does your child have any additional needs/ challenging behaviours?

☐ Yes ☐ No If yes please provide details

Do you have any concerns regarding your child's development, eating or sleep patterns?

☐ Yes ☐ No If yes please provide details

Office Use Only

Received By: **Date Received:**