

I understand Amanda's staff reserve the right to seek professional guidelines in cases of suspected child abuse. \_\_\_\_\_ Yes \_\_\_\_\_ No

I understand Amanda's staff and Educators will plan an individual programme for this child. I will be consulted and the programme is made available to me. \_\_\_\_\_ Yes \_\_\_\_\_ No

I understand that the Ministry of Education regulations forbid the use of corporal punishment. \_\_\_\_\_ Yes \_\_\_\_\_ No

I understand that the Ministry of Education requires that all food and drink that children consume is recorded. \_\_\_\_\_ Yes \_\_\_\_\_ No

I give permission for this child to travel in the Educators vehicle, in an approved restraint. \_\_\_\_\_ Yes \_\_\_\_\_ No

I give permission for this child to travel by public transport on excursions and outings. These will be part of every day planned family routines. \_\_\_\_\_ Yes \_\_\_\_\_ No

I give permission for this child to be taken for walks by the Educator. \_\_\_\_\_ Yes \_\_\_\_\_ No

I give permission for this child to attend Community Playgroups and Music Groups. \_\_\_\_\_ Yes \_\_\_\_\_ No

I accept responsibility for any expenses incurred in obtaining treatment for this child in an emergency situation. \_\_\_\_\_ Yes \_\_\_\_\_ No

I give permission for Educators to apply basic first aid and sunscreen products to this child and to change his/her soiled or wet clothing when necessary. \_\_\_\_\_ Yes \_\_\_\_\_ No

I give permission for this child to be taken to an alternative emergency location, e.g. civil defence centre, in the event of an emergency. \_\_\_\_\_ Yes \_\_\_\_\_ No

Special requirements in respect of my child are: *(including food)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tacita Limited  
PO Box AMSC 91631  
Auckland 1142  
New Zealand

# Amanda's

HOME BASED EARLY CHILDHOOD CARE AND EDUCATION

Telephone (09) 360 7514  
Fax (09) 360 1526  
After hours (021) 822 482  
amanda@amandas.org.nz

## CONFIDENTIAL

### ENROLMENT FORM

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*Unique Number*

#### CHILD

First Name(s) \_\_\_\_\_

Family Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Date of Birth \_\_\_\_\_ Female/Male \_\_\_\_\_

Language spoken at home \_\_\_\_\_

Ethnic Origin \_\_\_\_\_ Iwi/Hapu \_\_\_\_\_

#### PARENT / GUARDIAN / WHANAU

#### PARENT / GUARDIAN / WHANAU

Name \_\_\_\_\_

Name \_\_\_\_\_

Address *(if different from child)* \_\_\_\_\_  
\_\_\_\_\_

Address *(if different from child)* \_\_\_\_\_  
\_\_\_\_\_

Phone *(home)* \_\_\_\_\_

Phone *(home)* \_\_\_\_\_

Phone *(mobile)* \_\_\_\_\_

Phone *(mobile)* \_\_\_\_\_

Fax \_\_\_\_\_

Fax \_\_\_\_\_

Email address \_\_\_\_\_

Email address \_\_\_\_\_

Place of work \_\_\_\_\_  
\_\_\_\_\_

Place of work \_\_\_\_\_  
\_\_\_\_\_

Phone *(work)* \_\_\_\_\_

Phone *(work)* \_\_\_\_\_

**EMERGENCY CONTACT** - *must be in addition to parent.*

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Relationship to child \_\_\_\_\_

\_\_\_\_\_

**IMPORTANT INFORMATION**

Only those persons named below will be allowed to collect your child from the Educators home.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Is any person expressly forbidden to have access to your child  Yes  No

**ENROLLED HOURS**

MONDAY	start: _____ finish: _____	INCOME SUPPORT SUBSIDY
TUESDAY	start: _____ finish: _____	
WEDNESDAY	start: _____ finish: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
THURSDAY	start: _____ finish: _____	<input type="checkbox"/> Form required
FRIDAY	start: _____ finish: _____	
SATURDAY	start: _____ finish: _____	<input type="checkbox"/> Form enclosed
SUNDAY	start: _____ finish: _____	

**START DATE** \_\_\_\_\_

I understand that fees are charged for the provided Education and Care of my child and that I am responsible for these.

Name \_\_\_\_\_ Name \_\_\_\_\_

Signed \_\_\_\_\_ Signed \_\_\_\_\_

Dated \_\_\_\_\_ Dated \_\_\_\_\_

**PLEASE NOTE:** Any changes to enrolment arrangements must be immediately notified to the Educator and a staff member of Amanda's.

**MEDICAL INFORMATION**

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Please record details of special health care needs - including allergies and any medication required.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*For long term medication e.g. Ventolin, parents must provide a letter from a Doctor giving permission for the Educator to administer.*

Is your child enrolled at a Dental Clinic  Yes  No

**HAS YOUR CHILD HAD THESE IMMUNISATIONS?**

	VACCINE	YES	NO	UNSURE
6 weeks	DTaP-IPV ( <i>Diphtheria, tetanus, acellular pertussis, polio</i> ) HibHepB ( <i>Haemophilus influenzae type B, Hepatitis B</i> )	_____	_____	_____
3 months	DTaP-IPV ( <i>Diphtheria, tetanus, acellular pertussis, polio</i> ) HibHepB ( <i>Haemophilus influenzae type B, Hepatitis B</i> )	_____	_____	_____
5 months	DTaP-IPV ( <i>Diphtheria, tetanus, acellular pertussis, polio</i> ) HepB ( <i>Hepatitis B</i> )	_____	_____	_____
15 months	DTaP ( <i>Diphtheria, tetanus, acellular pertussis/Hib</i> ) MMR ( <i>Measles-mumps-rubella</i> )	_____	_____	_____
4-5 years (before school)	DTaP-IPV ( <i>Diphtheria, tetanus, acellular pertussis, polio</i> ) MMR ( <i>Measles-mumps-rubella</i> )	_____	_____	_____