



**PORT KENNEDY ASSOCIATION INCORPORATED**

PO Box 114, Thursday Island, QLD, 4875

Ph: 07 4069 2306 Fax: 07 4069 1977

**VACATION CARE PROGRAM  
ENROLMENT FORM**

**CHILD INFORMATION**

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_

Middle Name: \_\_\_\_\_ Sex:  Male  Female

Does your child speak any languages other than English at home?  No  Yes

If yes, what language/s are spoken at home: \_\_\_\_\_

Date of birth : \_\_\_\_\_ Starting Date: \_\_\_\_\_

**MOTHER / GUARDIAN 1**

Title: \_\_\_\_\_ Name: First: \_\_\_\_\_ Last: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred method of correspondence: *(Please tick)*

- Phone
- Email
- Postal Services

Occupation/Course: \_\_\_\_\_

Employer : \_\_\_\_\_

Aboriginal  Torres Strait Islander  Not Aboriginal or Torres Strait Islander  
*(Tick more than one, if relevant)*



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**FATHER / GUARDIAN 2**

Title: \_\_\_\_\_ Name: First: \_\_\_\_\_ Last \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Occupation/Course: \_\_\_\_\_

Employer : \_\_\_\_\_

Aboriginal  Torres Strait Islander  Not Aboriginal or Torres Strait Islander  
(Tick more than one, if relevant)

**MEDICAL INFORMATION**

**FAMILY DOCTOR:** \_\_\_\_\_

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

**MEDICARE NUMBER:**

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Allergies: \_\_\_\_\_

Does your child take regular medication? Yes/No (Please circle)

If yes please give details and advise any side effects:

\_\_\_\_\_  
\_\_\_\_\_

Does your child suffer from Asthma? Yes / No Medication: \_\_\_\_\_

History of any major illness/operation: \_\_\_\_\_

Is your child restricted from any activities (eg swimming, high level physical activity)? If yes, please give details. Outline any conditions that Affect your child's participation in specific activities:

\_\_\_\_\_  
\_\_\_\_\_



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**EMERGENCY CONTACTS (other than parent (s) / guardian)**

**Contact 1:** \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

**Contact 2:** \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

**AUTHORISATION FOR COLLECTION OF CHILD (other than parent (s) / guardian)**

**Name of Person (1) Authorised to Pick-up:** \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

**Name of Person (2) Authorised to Pick-up:** \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

**Details of any court orders affecting the custody of the child:** \_\_\_\_\_

\_\_\_\_\_



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**Parent/Guardian Consent:**

I \_\_\_\_\_ give consent for my child \_\_\_\_\_ (*name of child*) to participate in any of the Vacation Care program activities and/or excursions, during the school holidays **29/03/2016** to **08/04/2016**. I absolve the Port Kennedy Association from any responsibility of liability in the case of any accident or misfortune which may occur whilst my child attends the program.

**MEDICAL**

In the case of an accident, or any other emergency resulting in the need for immediate medical or dental attention, I / we hereby consent to the Coordinator or her / his designated representatives/s to obtain such ambulance, medical, dental, and / or hospital assistance as is required and agree to meet all expenses thereby incurred.

**VIDEOING/PHOTOGRAPHS**

I / We consent to my / our child being videoed or photographed in any video or photograph conducted or commissioned by the service for marketing / promotional and reporting purposes.

**USE OF INFORMATION**

I / We give the service my / our consent to use the information contained in this form, in keeping with the Information Handling Policy and the other Policies and Procedures of the Service.

**POLICIES AND GUIDELINES**

I / We have read the rules, regulations and requirements pertaining to the provision of after school and vacation care in this form and in the separate *Parent Handbook*. I / We acknowledge that I / we fully understand and agree to abide by all conditions appearing in this form, in any notices, and the Handbook, as amended from time to time. I / we declare that the information given above is accurate and agree to notify the Coordinator or the centre immediately there is any change to the above information.

**Any Exceptions? (Please indicate if you do not give consent to any of the above)** \_\_\_\_\_  
\_\_\_\_\_

**Signature of parent / guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_