St John's Catholic Primary School Baradine

Catholic Education Diocese of Bathurst Limited
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Kindergarten Transition Program Enrolment Form

SECTION 1 - Family Details *When completing the enrolment please print* *(original documents to be sighted and copies to be retained by school)*		
Family Surname:		Mailing Title e.g. Mr,Mrs,Ms,Miss
First Name/s:		
No. and Street Name:		
Suburb:	State:	Postcode:
Phone:	Main language spoken at home:	
E-mail Address:		

SECTION 2 – "Kick Start to Kindy" participant details		
Full Name:		Preferred first name:
Male ☐	Female ☐	Date of Birth:
Aboriginality: No ☐	Aboriginal ☐	Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander ☐
Nationality:		Country of birth:

SECTION 3 – Emergency Contact
Name:
Address:
Phone:

SECTION 4
What type(s) of care outside of home does your child have? (Please indicate)
Long Day Care ☐ Family Day Care ☐ Occasional Care ☐ Pre-school ☐ Playgroup ☐
Extent of Care: Up to 6 hours per week ☐ Up to 12 hours per week ☐ 12 hours to full-time each week ☐

SECTION 5 – Taking / Use of Photographs

I give permission for photographs of my child to be taken / used for:

School Publications Yes ☐ No ☐ Diocesan publications Yes ☐ No ☐ Internet Publications Yes ☐ No ☐

SECTION 6 – Special Circumstances

Who are the nominated people to collect your child after school if the parent is not available?

1. _____
2. _____
3. _____

Are there any special circumstances that the school should know. EG Behavioural/medical concerns, court orders, parental supervision?

_____

_____

SECTION 6 – Medical Details

Doctor's Name:

Medicare No: Expiry Date: Private Health Fund:

Medical Conditions*:*
Please specify any medical conditions, e.g. asthma, diabetes and / or any prescribed medication taken

Allergies: Yes ☐ No ☐
Please list any known allergies e.g. allergy to nuts, eggs, dairy, penicillin, bee stings or any medication including specific details:

Has your child been diagnosed as being at risk of anaphylaxis? Yes ☐ No ☐
If yes, does your child have and Epipen? Yes ☐ No ☐

Medical Treatment Permission

If my child should require urgent medical treatment, I authorise the school staff to seek medical attention and I agree to meet all costs.

Signed: Date:

Signed: . . . . . Date: . . . . . .

Parent / guardian