



Child's details:		
Child's official surname or family name:		
Child's official given name:		
Child's official other names / middle names: (please separate names with a comma):		
Name your child is known by / preferred name:		
Surname / family name:	Given name:	
Copy of official identity verification document* collected by staff:		
<input type="checkbox"/> New Zealand birth certificate <input type="checkbox"/> New Zealand passport <input type="checkbox"/> Other _____	<input type="checkbox"/> Foreign birth certificate <input type="checkbox"/> Foreign passport Staff initials: _____	
Child's date of birth (dd/mm/yyyy): _____ Male <input type="checkbox"/> Female <input type="checkbox"/>		
Child's ethnic origin/s: _____ _____ _____	Iwi your child belongs to: _____ _____ _____	Language/s spoken at home: _____ _____ _____
Child's primary residential address: _____ _____		
Post Code:		
Privacy Statement:		
<p>We are collecting personal information on this enrolment form for the purposes of providing early childhood education for your child.</p> <p>We will use and disclose your child's information only in accordance with the Privacy Act 2020. Under that Act you have the right to access and request correction of any personal information we hold about you or your child.</p> <p>Details about your child's identity will be shared with the Ministry of Education so that it can allocate a national student number for your child. This unique identifier will be used for research, statistics, funding, and the measurement of educational outcomes.</p> <p>You can find more information about national student numbers at: eli.education.govt.nz</p>		
<p>Information about acceptance identity verification documents is available online at eli.education.govt.nz</p> <p>The Ministry recommends that all services keep a copy of the identity verification document of each child who is enrolled at the service.</p>		

Parents / Guardians:	
1. Given names:	2. Given names:
Surname / family name:	Surname / family name:
Address:	Address:
Post Code:	Post Code:
Phone (Home):	Phone (Home):
Phone (Work):	Phone (Work):
Phone (Mobile):	Phone (Mobile):
Email:	Email:
Relationship to child:	Relationship to child:
3. Given names	4. Given names
Surname / family name:	Surname / family name:
Address:	Address:
Post Code:	Post Code:
Phone (Home):	Phone (Home):
Phone (Work):	Phone (Work):
Phone (Mobile):	Phone (Mobile):
Email:	Email:
Relationship to child:	Relationship to child:
Additional person/s who can pick up your child:	
Given names	Given names
Surname / family name:	Surname / family name:
Address:	Address:
Post Code:	Post Code:
Phone (Home):	Phone (Home):
Phone (Work):	Phone (Work):
Custodial Statement:	
Are there any custodial arrangements concerning your child?	
If YES , please give details on any custodial arrangements or court orders (a copy of any court order is required)	
Person/s who <u>cannot</u> pick you your child:	
Name:	Name:
Name:	Name:

Additional Emergency Contacts (also able to pick up child):	
1. Given names:	2. Given names:
Surname / family name:	Surname / family name:
Address:	Address:
Post Code:	Post Code:
Phone (Home):	Phone (Home):
Phone (Work):	Phone (Work):
Phone (Mobile):	Phone (Mobile):
Email:	Email:
3. Given names:	4. Given names:
Surname / family name:	Surname / family name:
Address:	Address:
Post Code:	Post Code:
Phone (Home):	Phone (Home):
Phone (Work):	Phone (Work):
Phone (Mobile):	Phone (Mobile):
Email:	Email:
Child's doctor:	
Name:	Phone:
Name of Medical Centre:	
Health	
Illness/allergies:	
Is your child up-to-date with immunisations? <i>Tick one</i> Yes <input type="checkbox"/> No <input type="checkbox"/>	
(Please provide verification of all immunisations)	
For Staff: Immunisations records sighted and details recorded: <i>Tick one</i> Yes <input type="checkbox"/> No <input type="checkbox"/>	
Food Recommendations	
Have read Ministry of Health document Reducing food-related choking for babies and young children at early learning services and are aware of the Ministry of Health's recommendations for reducing the risk of choking in babies and young children.	
Signed: _____ Date: _____	
Sunblock	
I agree to sun blocking my child before arriving at the centre and Kidlywinks to reapplying it to my child after lunch.	
Signed: _____ Date: _____	

Medicine	
Category (i) Medicines	
A category (i) medicine is a non-prescribed preparation (such as arnica cream, antiseptic liquid, insect bite treatment, sudo cream, sun block) that is not ingested, used for the 'first aid' treatment of minor injuries and provided by the service and kept in the first aid cabinet.	
Note: The service must provide specific information about the category (i) preparations that will be used.	
Do you approve category (i) medicines to be used on your child? Tick one Yes <input type="checkbox"/> No <input type="checkbox"/>	
Name/s of specific category (i) medicines that can be used on my child, provided by service:	
•	•
•	•
Parent/Guardian Signature: _____	Date: ____/____/____

Category (ii) Medicines	
Category (ii) medicines are prescription (such as antibiotics, eye/ear drops etc) or non-prescription (such as paracetamol liquid, cough syrup etc) medicine that is used for a specific period of time to treat a specific condition or symptom, provided by a parent for the use of that child only or, in relation to Rongoa Māori (Māori plant medicines), that is prepared by other adults at the service.	
I acknowledge that written authority from a parent is to be given at the beginning of each day a category (ii) medicine is to be administered, detailing what (name of medicine), how (method and dose), and when (time or specific symptoms/circumstances) medicine is to be given.	
Parent/Guardian Signature: _____	Date: ____/____/____
Category (iii) Medicines	
To be filled in if your child requires medication as part of an individual health plan, for example for an on-going condition such as asthma or eczema etc and is for the use of that child only.	
For Staff: Individual health plan sighted and a copy taken: Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Tick one</i>	
Name of medicine:	
Method and dose of medicine:	
When does the medicine need to be taken (State time or specific symptoms):	
Parent/Guardian Signature: _____	Date: ____/____/____

Enrolment Details:						
Date of Enrolment: ___/___/___ (Form filled in) Date of Entry: ___/___/___ (Requested Start Date)						
Office use only Date of Exit: ___/___/___ (Leaving Date) APT Entry: ___/___/___						
Please Note: 20 Hours ECE is for up to six hours per day , up to 20 hours per week and there must be no compulsory fees when a child is receiving 20 Hours ECE Funding.						
Days Enrolled	Monday	Tuesday	Wednesday	Thursday	Friday	
Times Enrolled						Total hours:
For 20 Hours ECE fill out boxes below with the hours attested e.g. 6 hours						
20 Hours ECE at this service						Total hours:
20 Hours ECE at another service						Total hours:
Parent/Guardian Signature: _____ Date: ___/___/___						

20 Hours ECE Attestation:		
1. Is your child receiving 20 Hours ECE for up to six hours per day, 20 hours per week at this service?		
	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Is your child receiving 20 Hours ECE at any other services?		
	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes to either or both of the above, please sign to confirm that:		
<ul style="list-style-type: none"> Your child does not receive more than 20 hours of 20 Hours ECE per week across all service. You authorise the Ministry of Education to make enquiries regarding the information provided in the Enrolment Agreement Form, if deemed necessary and to the extent necessary to make decisions about your child' eligibility for 20 Hour ECE. You consent to the early childhood education service providing relevant information to the Ministry of Education and to other early childhood education services your child is enrolled at, about the information contained in this box. 		
Parent/Guardian Signature: _____ Date: ___/___/___		

Dual Enrolment Declaration	
I hereby declare that my child is/is not enrolled at another early childhood institution at the same times that he/she is enrolled at Kidlywinks Childcare Centre.	
Parent/Guardian Signature: _____ Date: ___/___/___	

Change of Days/Times of Enrolment:						
Effective Date of Change: ___/___/___						
Days Enrolled	Monday	Tuesday	Wednesday	Thursday	Friday	
Times Enrolled						Total
For 20 Hours ECE fill out boxes below						
20 Hours ECE at this service						
20 Hours ECE at another service						
Parent/Guardian Signature: _____			Date: ___/___/___			

Change of Days/Times of Enrolment:						
Effective Date of Change: ___/___/___						
Days Enrolled	Monday	Tuesday	Wednesday	Thursday	Friday	
Times Enrolled						Total
For 20 Hours ECE fill out boxes below						
20 Hours ECE at this service						
20 Hours ECE at another service						
Parent/Guardian Signature: _____			Date: ___/___/___			

Permissions	
Excursions: Permission for the child to take part in regular excursions (under the conditions stated in the excursions policy).	Yes <input type="checkbox"/> No <input type="checkbox"/>
Photo/video: permission for the child to be photographed for the purposes of assessment, planning and evaluation	Yes <input type="checkbox"/> No <input type="checkbox"/>
Public Facebook page: permission for the child to be photographed for the purpose of advertising/promoting the centre.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Private Family Facebook page: permission for the child to be photographed for the purposes of sharing daily/weekly updates of the children's learning with family.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Public/Promotional Instagram page and Website: permission for the child to be photographed for the purposes of advertising/promotion of the centre.	Yes <input type="checkbox"/> No <input type="checkbox"/>

Parent Declaration	
I declare that all the above information is true and correct to the best of my knowledge.	
Parent/Guardian Signature: _____	Date: ____/____/____

Service Declaration	
On behalf of Kidlywinks Childcare Centre, I declare that this form has been checked and all relevant sections have been completed.	
Service Provider Signature: _____	Date: ____/____/____