



**ENROLMENT FORM**

Child's first names:	Surname:
Name your child is known by:	
Child's date of birth:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Ethnic origin:	
Iwi your child belongs to:	Rohe (Iwi home area):
Child's home address or addresses:	
Postcode	

**Parents / Guardians:**

Name:	Name:
Relationship to child:	Relationship to child:
Address:	Address:
Post Code:	Post Code:
Phone (Home):	Phone (Home):
Phone (Work):	Phone (Work):
Phone (Mobile):	Phone (Mobile):
Email:	Email:

**Emergency Contacts:**

Name:	Name:
Relationship to child:	Relationship to child:
Address:	Address:
Post Code:	Post Code:
Phone (Home):	Phone (Home):
Phone (Work):	Phone (Work):
Phone (Mobile):	Phone (Mobile):
Email:	Email:

Only those persons listed below will be allowed to collect the child etc	Phone numbers

**Custodial Statement**

Are there any custodial arrangements concerning your child?

If **YES**, please give details of any custodial arrangements or court orders (a copy of any court order is required)

**Person/s who cannot pick up your child:**

Name:	Name:
Name:	Name:

School the child is likely to attend:

Doctor:	
Name:	Phone:
Address:	

Health	
Illness/allergies:	
Is your child up-to-date with immunisations?	Tick One Yes <input type="checkbox"/> No <input type="checkbox"/>
(Please provide verifications of all immunisations)	
Immunisations record sighted and details recorded:	Tick One Yes <input type="checkbox"/> No <input type="checkbox"/>

Medicine	
<b>Category (i) Medicines</b>	
A category (i) medicine is a non-prescription preparation (such as arnica cream, antiseptic liquid, insect bite treatment) 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, <b>provided by service</b> :	
▪	▪
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	
Individual health plan completed and signed:	Tick One Yes <input type="checkbox"/> No <input type="checkbox"/>
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: ____/____/____	

I understand that staff are responsible for this child only during session times and that I am responsible for seeing that this child gets to and from the kindergarten safely.	Yes <input type="checkbox"/> No <input type="checkbox"/>
I understand that I will be required to give written consent for any planned excursion.	Yes <input type="checkbox"/> No <input type="checkbox"/>
I give permission for my child to attend regular excursions where regulated ratios must apply.	Yes <input type="checkbox"/> No <input type="checkbox"/>
I give permission for my telephone number and/or address to be made available for kindergarten purposes.	Yes <input type="checkbox"/> No <input type="checkbox"/>
I give permission for staff to apply basic first aid	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Privacy Statement:** All personal information on your child will be kept securely and remain confidential. Any changes to this form **must** be signed and dated by the parent/guardian.

I give permission for staff to assist changing his/her soiled or wet clothing when necessary.	Yes <input type="checkbox"/> No <input type="checkbox"/>
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I give permission for my child and other family members to be videoed/photographed while involved in learning experiences at kindergarten or while involved in an excursion. These images may be viewed by families of other children involved in the same footage.	Yes <input type="checkbox"/> No <input type="checkbox"/>
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We hereby give authority in the case of an emergency that our child be transported to hospital by ambulance.  Signed: ..... Date: .....	Yes <input type="checkbox"/> No <input type="checkbox"/>
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We hereby accept that all reasonable care and steps shall be taken in the care and protection of our child ..... while at kindergarten and/or while in transit to hospital.  Signed: ..... Date: .....	Yes <input type="checkbox"/> No <input type="checkbox"/>
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We accept that all attempts to contact us will be made by the teachers, and/or our emergency contact person ..... at ..... should this be required.  Signed: ..... Date: .....	Yes <input type="checkbox"/> No <input type="checkbox"/>
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<b>Please tell us about your child's strengths, interests and preferences:</b>

<b>Enrolment Details:</b>
Date of Enrolment: ___/___/___      Date of Entry: ___/___/___      Date of Exit: ___/___/___

**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 number of hours:

**For 20 Hours ECE fill out boxes below with the hours attested e.g. 6 hours**

20 Hours ECE at this service						Total number of hours:
20 Hours ECE at another service						Total number of hours:

Parent/Guardian Signature: _____	Date: ___/___/___
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**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?

*Tick One*    Yes     No

2. Is your child receiving 20 Hours ECE at any other services?

*Tick One*    Yes     No

If yes to either or both of the above, please sign to confirm that:

- Your child does not receive more than 20 hours of 20 Hours ECE per week across all services.
- 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's eligibility for 20 Hours 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

**I have agreed to the following:**

I will allocate my child's 20 hours ECE to this Kindergarten.

If I do not use my child's 20 hours ECE allocation at this Kindergarten, I understand that a voluntary contribution of \$1.50 per hour will be requested.

I agree to the above and that the information provided is true and correct.

Yes     No

**Statutory Holidays/Term Breaks**

- This enrolment agreement is exclusive of school term breaks.
- All kindergartens belonging to the Heretaunga Kindergarten Association will be closed on public holidays.

**Dual Enrolment Declaration**

I hereby declare that my child is not enrolled at another early childhood institution at the same times that he/she is enrolled at

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

- **Policy Statement:** Heretaunga Kindergarten Association has a number of policies that set out the procedures that are in place for the care and education of the children who attend. We strongly urge you to read these. The signing of this enrolment agreement form indicates that you will abide by the policies of this service, and understand how you can have input to policy review.
- **Parent Information Book:** Please ensure you have read the information in the parent handbook as it covers such things as contributions and subsidies that are available to you and ways in which we can help you and your child settle into the service.

**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 the Heretaunga Kindergarten Association I declare that this form has been checked and all relevant sections have been completed.

Teacher Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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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: ___ / ___ / ___						

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: ___ / ___ / ___						

## CHILD HEALTH PROGRAMME

This form requests **your consent** for the Vision Hearing Technician to carry out free checks as outlined. Your child's name, date of birth, ethnicity and National Health Index (NHI) number will be recorded by the Vision and Hearing Technician and stored in the B4 School Check national information system, along with the results of the Check. This information can only be used by authorised people who are working with your child and are co-ordinating the B4 School Check, or who are managing the system. The results of the test will be given to your child's early childhood education centre, kohanga reo, and/or school.

### PLEASE COMPLETE THIS FORM

**Early Childhood Centre:** \_\_\_\_\_

**Child's Name:** \_\_\_\_\_  
(First Name) (Family Name)

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

**Date of Birth:** \_\_\_\_\_ **National Health Index (NHI) if known:** \_\_\_\_\_

**Ethnicity:** NZ/European  Maori  Pacific Island  Asian  Other

**Parents/Guardians Names:** \_\_\_\_\_

**Telephone:** Home/Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**Doctor's Name:** \_\_\_\_\_

	Yes	No
Within the last six months has your child seen an ear specialist or audiologist?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever had grommets?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child wear a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>
Within the last six months has your child seen an eye specialist or optometrist?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>

**Comments:** \_\_\_\_\_

The Vision/Hearing Technician may carry out these screening tests:

- **B4 School Check Distance vision**
- **B4 School Check Hearing (Audiometry)**
- **Middle ear function (glue ear check/tympanometry)**

Vision/Hearing Technicians and an Ear Nurse are available to discuss any vision and hearing concerns with you and they can be contacted through the Early Childhood Education Centre.

You will be contacted if there are any concerns regarding your child's results.

### CONSENT

I \_\_\_\_\_ consent to the following checks being carried out on my child:  
(Full name of parent/guardian)

<b>Please tick:</b>	<b>Yes</b>	<b>No</b>
Vision (eyes)	<input type="checkbox"/>	<input type="checkbox"/>
Middle Ear Function (glue ear check/tympanometry)	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Check (Audiometry)	<input type="checkbox"/>	<input type="checkbox"/>
Ear Check	<input type="checkbox"/>	<input type="checkbox"/>

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Parent/Guardian)

B4 School Check national information system is held in accordance to B4 School Check national information system privacy policy. For more information on the policy see <http://www.moh.govt.nz/b4schoolcheck>.

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