

Program Enquiry Form



Office Use Only

Initial Support Officer: _____ Appointment Date: ____/____/____

Date of Enquiry: ____/____/____ Do you identify as: ATSI [] CALD []

Concession Card? Y [] Child Allergies: Y [] N [] if yes, details: _____

Type of grief / loss? (please circle) SEPARATION ILLNESS DEATH OTHER

CONTACT DETAILS

Primary Caregiver: (relationship) _____

First Name: _____ Surname: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Phone: () _____ Mobile: _____ Work: () _____

School: _____ Referral Organisation: _____

Email: _____

CHILD ONE

First Name: _____ Middle Name: _____

Last Name: _____ Program? _____ Day? _____

Gender: (please circle) Boy Girl Date of Birth: ____/____/____ Current Age: _____

CHILD TWO

First Name: _____ Middle Name: _____

Last Name: _____ Program? _____ Day? _____

Gender: (please circle) Boy Girl Date of Birth: ____/____/____ Current Age: _____

CHILD THREE

First Name: _____ Middle Name: _____

Last Name: _____ Program? _____ Day? _____

Gender: (please circle) Boy Girl Date of Birth: ____/____/____ Current Age: _____

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QUESTIONS

Has your child been diagnosed with, or do you suspect that your child is suffering from any health or medical condition?

Diagnosed: _____

Suspected: _____

Please describe any behaviours that are particularly concerning to you or others:

Has your child ever been exposed to any traumatic or stressful events such as addictions, domestic violence or similar?

EMERGENCY CONTACT

Full Name: _____ Contact No. _____

Relationship to you: _____ (friend or relative not at the same address as you)

The above information is true to the best of my knowledge. Y [] N [] I authorise Paradise Kids to contact other departments/services/medical surgeries if required to access further information about my child. Y [] N [] I would like to be informed by Paradise Kids of special events and programs that are of value to me and my child. Y [] N []

Parent / Caregiver Full Name: _____

Signature: _____ Date: ____/____/____