



WAITING LIST APPLICATION

All information on this form is CONFIDENTIAL.

1. CHILD'S DETAILS					
First Name:			Surname:		
Date of Birth:	___/___/___		Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Residential Address:					
	Town:	State:		Postcode:	
Nationality:			Country of Birth:		
Religion:			Language/s spoken at home:		
Is child recognised as from Aboriginal or Torres Strait Island background?				<input type="checkbox"/> Yes	<input type="checkbox"/> No

2. PARENT / GUARDIAN DETAILS				
	Parent 1		Parent 2	
First Name				
Surname				
Salutation	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Other _____		<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Other _____	
Relationship to child				
Residential Address	<input type="checkbox"/> same as child Other: _____		<input type="checkbox"/> same as child Other: _____	
Preferred Phone	<input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work	_____	<input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work	_____
Alternate Phone	<input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work	_____	<input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work	_____
Email (please print clearly)				
Nationality				
Birth Country				
Background	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Island		<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Island	

3. HEALTH / MEDICAL INFORMATION

Does your child have a Health Care Card? (Not medicare)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Health Care Card Number:	_____		EXP: ___ / ___ / ___
Do you or your doctor / health professional have any concerns with your child's development?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Has your child ever attended Early Intervention? <input type="checkbox"/> Yes	
Details:			
Does your child suffer from allergies / asthma?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Details:			

4. ACKNOWLEDGEMENT OF WAITING LIST PROCEDURE

- I acknowledge completion of this application form and payment of waiting list fee is not a guarantee that my child will be offered a position.*
- I acknowledge my child will remain on waiting list until he/she is offered a place, I withdraw their application, or they commence attending school.*
- I will advise the office if our details change.*
- I acknowledge this application is not transferrable between children and waiting list fee is not refundable.*

Signature	Name	Date

5. PAYMENT OF FEE

To confirm your application, payment of \$15.00 fee must be made at time of submission;

Electronic Funds Transfer	Cheque	Cash
Elizabeth Chifley Pre-School BSB: 637 000 (Greater Bank) Account No: 781 776 947	Made payable to Elizabeth Chifley Pre-School	Payable at office during school hours

OFFICE USE ONLY		
Receipt No	Date Received	Entered in Register