



KINGSTON BEACH EDUCATIONAL CARE

Educators Information Form

This information is made available to your child's Educators.

Child's Name: _____ Date of Birth: _____

Primary Languages spoken by child: _____ By parents: _____

Cultural/Ethnic background: _____

Family Doctor's Name, address and phone: _____

Is your child of Aboriginal and/or Torres Straight Island Origin?

No Yes, Aboriginal Yes, Torres Strait Islander

CONTACT DETAILS

	Parent / Guardian 1	Parent / Guardian 2
Surname		
Given Names		
Relationship to Child		
Home phone		
Work phone		
Mobile phone		

FAMILY INVOLVEMENT

Do you or any members of your family have any interests or skills, which could be included in the program? *If so please give details:* _____

Does your child have any allergies? Yes No

If yes please give details: _____

Does your family have any religious or cultural beliefs that you would like us to follow (including diet requirements): _____

Present Medical Treatment, if any (including medication)? _____

Any additional needs (ie special comforts, eating, sleeping, toilet routines, developmental concerns, diagnoses/undergoing assessment etc): _____

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HAS PERMISSION BEEN GIVEN FOR:

- | | | |
|--|------------------------------|-----------------------------|
| 1. Administering Paracetamol | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Observation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Photographs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Excursions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Emergency Medical Treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Applying Sunscreen | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Applying Non-Scheduled Creams and Ointments | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. 8. Health plans to be displayed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

PEOPLE AUTHORISED BY PARENTS / GUARDIANS TO COLLECT CHILD FROM SERVICE.

(Other than parents / guardians)

Name: _____ Phone: _____

Name: _____ Phone: _____

ANY OTHER COMMENTS OR INFORMATION THAT WOULD BE USEFUL TO US

Signature of Parent / Guardian: _____ Date: _____

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Child Profile

This information will help us to get to know your child and cater for his/her needs.

Child's Name: _____

Names and ages of brothers and sisters:

Name	Age

What are your child's favourite toys? _____

What are your child's favourite pastimes? _____

Does your child have any particular dislikes or fears? _____

Does your child have a sleep during the day at home? Yes No

• at what time? _____

• how long? _____

Does your child have a comforter? (dummy, special toy) _____

Any other bedtime requirements? _____

What does your child eat during the day at home? _____

Snacks	
Lunch	
Drinks	

Is your child toilet-trained? Yes No

Do you have any pets? Yes No

If so, what are their names?

Does your child have any special needs? _____

Are you happy for your child to be involved in activities to celebrate:

- Christmas Yes No
- Easter Yes No
- Birthdays Yes No
- Mother's Day Yes No
- Father's Day Yes No
- Other Cultural Celebrations Yes No

Is there any other information that you think would be useful to us? _____
