

# Child's Confidential Record Amendment

## Child Youth & Family Enrolment Guidelines attachment 1

This form should be completed by a parent when the details provided on the *Child's Confidential Record* change. If assistance is required please contact your educator or the City of Casey on 9705 5200

### 1. Information about the child

Given name/s: \_\_\_\_\_ Family name \_\_\_\_\_

Child's home address: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

### 2. Change of contact details for parent (if applicable)

#### Parent 1

Given name/s: \_\_\_\_\_ Family name: \_\_\_\_\_

Relationship to child:  Mother  Father  Other: \_\_\_\_\_

Does the child live with this parent?  Yes  No Address same as child:  Yes or:

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

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Name and location of work / study place: \_\_\_\_\_

Hours of work/study:  Full time  Part Time  Casual

Home phone: \_\_\_\_\_ Mobile phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Email address: \_\_\_\_\_

#### Parent 2 (if applicable)

Given name: \_\_\_\_\_ Family name: \_\_\_\_\_

Relationship to child:  Mother  Father  Other: \_\_\_\_\_

Does the child live with this parent?  Yes  No Address same as child:  Yes or:

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

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Name and location of work/study place: \_\_\_\_\_

Hours of work/study:  Full time  Part Time  Casual

Home phone: \_\_\_\_\_ Mobile phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Email address: \_\_\_\_\_

### 3. Change of circumstances relating to Court orders, parenting plans relating to the child

(a) Are there any changes  No  Yes, please attach evidence

### 4. Changes to Authorisations: (details of people you authorise as contacts for the child other than those listed as parents in section two)

You **cannot** authorise a City of Casey Family Day Care Educator if you are paying them for your child's care while your child is also attending kindergarten.

Only include people who are over 16 years of age and who are not already listed as parents

#### Please indicate the changes you wish to make to the authorities you provided on the *Child's Confidential Record*

- add a new authorised person (list below)
- remove an authorised person previously listed Name: \_\_\_\_\_
- replace all previously listed authorised persons with person listed below

#### Contact 1

Given name/s: \_\_\_\_\_ Family name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Mobile phone: \_\_\_\_\_  
Work phone: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

#### Please tick the box/es below to confirm the level of authorisation you give to this person

- Authorised to collect (Authorised Nominee)
- Authorise to be notified of an emergency involving the child if any parent cannot be contacted
- Authorised to consent to medical treatment
- Authorised to consent to administration of medication
- May authorise an educator to take the child outside the service on excursions/regular outings
- May authorise an educator to take the child outside the service premises

#### Contact 2

Given name/s: \_\_\_\_\_ Family name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Mobile phone: \_\_\_\_\_  
Work phone: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

#### Please tick the box/es below to confirm the level of authorisation you give to this person

- Authorised to collect (Authorised Nominee)
- Authorise to be notified of an emergency involving the child if any parent cannot be contacted
- Authorised to consent to medical treatment

- Authorised to consent to administration of medication
- May authorise an educator to take the child outside the service on excursions/regular outings
- May authorise an educator to take the child outside the service premises

**5. Changes to the child’s specific medical conditions**

Has the child been diagnosed with any of the following medical conditions?

- |             |                              |                             |               |                              |                             |
|-------------|------------------------------|-----------------------------|---------------|------------------------------|-----------------------------|
| Anaphylaxis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other medical | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If yes, please provide a Management Plan (available from a medical practitioner) that has been completed by the medical practitioner and contact your educator to complete a City of Casey Risk Minimisation & Communication Plan before returning your child to care.

Does your child have any new dietary restrictions?  Yes  No

If yes, please complete a dietary restrictions form.

I \_\_\_\_\_ (print full name) the

parent completing this form declare that the information in this Child’s Confidential Record Amendment is true and correct and undertake to immediately inform the educators at the service in the event of any change to this information.

Parent name: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Parent signature: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

