

Expression of interest

Preferred days of attendance (please select)

Date of application: _____

| | Monday | Tuesday | Wednesday | Thursday | Friday |
|--------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Before school care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| After school care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vacation Care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Casual days only

| Child details | Child 1 | Child 2 | Child 3 |
|---------------------|---|---|---|
| First Name | | | |
| Last name | | | |
| D.O.B. | | | |
| Gender | <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| School attending | | | |
| Class year | | | |
| Proposed start date | | | |

| Parent/Guardian 1 | | | Parent/Guardian 2 | | |
|------------------------|----|----|------------------------|----|----|
| Full name: | | | Full name: | | |
| DOB: | | | DOB: | | |
| Relationship to child: | | | Relationship to child: | | |
| Address: | | | Address: | | |
| T: | M: | W: | T: | M: | W: |
| Email: | | | Email: | | |

Other relevant information

Reason for care:

Other relevant information

Does your child have an additional need or require support? No Yes *(Please provide details.)*

Does your child have any allergies? No Yes *(Please provide type of allergy and details.)*

Work / Training / Study status *(Please indicate which of the following applies to you and, if relevant to your partner.)*

Parent / Guardian / Carer

Working full time Working part time Training / Studying

Partner

Working full time Working part time Training / Studying

Access priority

Does your child or your family identify as Aboriginal or Torres Strait Islander? No Yes

Does your child or someone in your immediate family have a disability? No Yes

Does your child speak primarily another language other than English? No Yes,

(Provide Language)

Does your family hold a low-income Health Care Card? No Yes

Are you a sole parent? No Yes