

Please email the completed form to cycteamb@thejunctionworks.org or return it to the program facilitator

Program: _____

PERSONAL DETAILS (ADULT/PARENT/GUARDIAN)			
Gender:		Date of Birth:	
Family Name:		Given Name:	
Address:			
Suburb:			Postcode:
Contact Number:		Email:	
Ancestry (culture you primarily identify with):			Disability: Yes <input type="checkbox"/> No <input type="checkbox"/>
Country of Birth:		Main Language Spoken at Home:	
Do you identify as Aboriginal or Torres Strait Islander?			
<input type="checkbox"/> No <input type="checkbox"/> Yes – Aboriginal <input type="checkbox"/> Yes - Torres Strait Islander			
Emergency Contact 1:			
Name:		Relationship:	
Phone Number		Email Address:	
Address:		Suburb and Postcode:	
Emergency Contact 2:			
Name:		Relationship:	
Phone Number:		Email Address:	
Address:		Suburb and Postcode:	

Do you have any allergies? If YES , please provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any special dietary requirements? If YES , please provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
*Do you have any medical conditions/disabilities that we need to be aware of? If YES , please provide details including any regular medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please complete the below section only if your child/ren are attending The Junction Works programs, if not please skip this section and complete the Consent section.

Child 1		
Family Name:		Given Name:
Address:		
Suburb:	Postcode:	Gender:
Date of birth:	Main language spoken at home:	
Country of Birth:	Aboriginal or Torres Strait Islander background? Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> No <input type="checkbox"/>	
Ancestry (culture client primarily identifies with):		
Allergies (please specify):		Yes <input type="checkbox"/> No <input type="checkbox"/>
Dietary Requirements (please specify):		Yes <input type="checkbox"/> No <input type="checkbox"/>
Is your child taking regular medication (please specify):		Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child have Asthma? <i>Asthma Management Plan is required.</i>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child have any special needs/disabilities that staff need to be aware of in providing care? (please specify)		Yes <input type="checkbox"/> No <input type="checkbox"/>

Child 2		
Family Name:		Given Name:
Address:		
Suburb:	Postcode:	Gender:
Date of birth:	Main language spoken at home:	
Country of Birth:	Aboriginal or Torres Strait Islander background? Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> No <input type="checkbox"/>	
Ancestry (culture client primarily identifies with):		
Allergies (please specify):		Yes <input type="checkbox"/> No <input type="checkbox"/>
Dietary Requirements (please specify):		Yes <input type="checkbox"/> No <input type="checkbox"/>
Is your child taking regular medication (please specify):		Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child have Asthma? <i>Asthma Management Plan is required.</i>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child have any special needs/disabilities that staff need to be aware of in providing care? (please specify)		Yes <input type="checkbox"/> No <input type="checkbox"/>

Child 3		
Family Name:		Given Name:
Address:		
Suburb:	Postcode:	Gender:
Date of birth:	Main language spoken at home:	
Country of Birth:	Aboriginal or Torres Strait Islander background? Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> No <input type="checkbox"/>	
Ancestry (culture client primarily identifies with):		
Allergies (please specify):		Yes <input type="checkbox"/> No <input type="checkbox"/>
Dietary Requirements (please specify):		Yes <input type="checkbox"/> No <input type="checkbox"/>
Is your child taking regular medication (please specify):		Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child have Asthma? <i>Asthma Management Plan is required.</i>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child have any special needs/disabilities that staff need to be aware of in providing care? (please specify)		Yes <input type="checkbox"/> No <input type="checkbox"/>

Where did you hear about this Service: (please tick)

<input type="checkbox"/>	Local Newspaper	<input type="checkbox"/>	Flyers	<input type="checkbox"/>	Word of Mouth
<input type="checkbox"/>	Website or Social Media	<input type="checkbox"/>	Other:		

CONSENT

CONSENT AND DECLARATIONS for (Participant, Parent, Carer/Guardian)

Please tick relevant answers and sign all consent statements:

I understand that this service will collect and store my/my child/ren's personal information in the Australian Government's Data Exchange system. This may include basic details about me/my child/ren and the support I receive. My/my child/ren's information will be kept secure and used only for service delivery, reporting and planning. Any information used for research or evaluation will not identify me/my child/ren	<input type="checkbox"/> Yes <input type="checkbox"/> No
By signing below, I give my consent for my/my child/ren's information to be collected and stored in the Data Exchange. I understand that giving consent is voluntary and that I can withdraw it at any time.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I agree to attend The Junction Works Communities, Youth & Children's Services and understand that employees and volunteers cannot be held responsible for any loss of property, damage, or accidents that may occur.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I give permission for medical assistance to be provided to me/my child/ren in the event of an emergency and agree to pay any associated costs.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I also grant The Junction Works staff permission to obtain relevant medical information about me/my child/ren if required in an emergency, including information relating to allergies, asthma, medical needs or medications.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I certify that all information in this enrolment form is correct at the time of signing. I agree to notify The Junction Works of any changes that may occur.	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>I give permission for myself to be featured (by name or by photo) in The Junction Works' event or news publicity, including for newsletters, expos, print and digital publications, website and social media material. Website: www.thejunctionworks.org</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>I give permission for auditors (from The Junction Works and/or independent) to view information about myself as part of The Junction Works Quality Assurance System and adherence to National Government Standards.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Name:

Signature:

Date:
