Longreach Regional Council
Ilfracombe Isisford Longreach Yaraka

Longreach and Districts Rural In Home Care Program
5-7 Wompoo Road, Longreach QLD 4730
Tel: (07) 46 525300
Email: attendancerecordsihc@longreach.qld.gov.au

LONGREACH IN HOME CARE ENROLMENT FORM 2020

RECEIVED DATE ____ / ____ / ___ AGENCY REFERRAL DATE ____ / ____ / ___

Note: An educator may not commence with a family until the documentation for all parties has been received to the coordination unit and an appropriate starting date has been organised with a service representative. If you choose to have an educator start before this time you will be responsible for the full cost of care.

PARENTS / GUARDIAN DETAILS

Parent/Guardian 1:

Surname: ..... Given Names: .....

Date of Birth: ..... Country of Birth: ..... Primary Language: .....

Department of Human Services CRN (Customer Reference Number): .....

Residential Address: .....

Postal Address: .....

Phone Number: ..... Mobile Telephone Number: .....

Email Address: .....

Work Place: ..... Phone Number: .....

Occupation: ..... Employment Status: Full Time ☐ Part Time ☐ Self Employed ☐

Parent/Guardian 2:

Surname: ..... Given Names: .....

Date of Birth: ..... Country of Birth: ..... Primary Language: .....

Department of Human Services CRN (Customer Reference Number): .....

Residential Address: .....

Postal Address: .....

Phone Number: ..... Mobile Telephone Number: .....

Email Address: .....

Work Place: ..... Phone Number: .....

Occupation: ..... Employment Status: Full Time ☐ Part Time ☐ Self Employed ☐

Parent / Guardian Claiming Childcare Subsidy: Parent/Guardian 1 ☐ Parent/Guardian 2 ☐

CHILD DETAILS

1. Child Family Name: ..... Child Given Names:.....

Date of Birth: ..... Gender: ☐ Male ☐ Female School aged child: ☐ Yes ☐ No

School Child Attends: ..... Country of Birth:.....

Department of Human Services CRN (Customer Reference Number): .....

Medicare Number: ..... Medicare Ref No: .....

Has your child any additional needs? If yes, please state:.....

.....

CHILD DETAILS

2. Child Family Name: ..... Child Given Names:.....

Date of Birth: ..... Gender: ☐ Male ☐ Female School aged child: ☐ Yes ☐ No

School Child Attends: ..... Country of Birth:.....

Department of Human Services CRN (Customer Reference Number): .....

Medicare Number: ..... Medicare Ref No: .....

Has your child any additional needs? If yes, please state:.....

.....

CHILD DETAILS

3. Child Family Name: ..... Child Given Names:.....

Date of Birth: ..... Gender: ☐ Male ☐ Female School aged child: ☐ Yes ☐ No

School Child Attends: ..... Country of Birth:.....

Department of Human Services CRN (Customer Reference Number): .....

Medicare Number: ..... Medicare Ref No: .....

Has your child any additional needs? If yes, please state:.....

.....

CHILD DETAILS

4. Child Family Name: ..... Child Given Names:.....

Date of Birth: ..... Gender: ☐ Male ☐ Female School aged child: ☐ Yes ☐ No

School Child Attends: ..... Country of Birth:.....

Department of Human Services CRN (Customer Reference Number): .....

Medicare Number: ..... Medicare Ref No: .....

Has your child any additional needs? If yes, please state:.....

.....

CHILD DETAILS

5. Child Family Name: …… Child Given Names:……

Date of Birth: …….. Gender: ☐ Male ☐ Female School aged child: ☐ Yes ☐ No

School Child Attends: …….. Country of Birth:……..

Department of Human Services CRN (Customer Reference Number): ……..

Medicare Number: …….. Medicare Ref No: ……

Has your child any additional needs? If yes, please state:……

……

Has your child been immunised for/with: (Please provide a copy of current immunisation statement)

National Immunisation Program Schedule – April 2019

National Immunisation Program Schedule 1 April 2019

Australian Government Department of Health

National Immunisation Program
A joint Australian, State and Territory Government initiative

	Childhood							Adolescent		Adult				
Vaccine Brand Name	Birth	2 mths (from 6 weeks)	4 mths	6 mths	12 mths	18 mths	4 yrs	12–<13 yrs (school programs)	14–<16 yrs (school programs)	Pregnant women	Indigenous* >15 yrs	Indigenous* >50 yrs	>65 yrs	70 yrs
H-B-Vax® II Paediatric or **Engerix® B – Paediatric** (Hep B)	✔ (within 7 days)													
Infanrix® hexa (DTPa, Hep B, Polio, Hib)		✔	✔	✔										
Prevenar 13® (Pneumococcal)		✔	✔	✔ Medically at-risk and Indigenous* (QLD, NT, WA, SA)	✔									
Rotarix® (Rotavirus)		✔	✔											
Nimenrix® (MenACWY)					✔				✔					
ActHIB® (Hib)						✔								
MMRII® or **Priorix®** (MMR)					✔									
Priorix-Tetra® or **ProQuad®** (MMRV)						✔								
Infanrix® or **Tripacel®** (DTPa)						✔								
Infanrix® IPV or **Quadracel®** (DTPa, Polio)							✔							
Vaqta® Paediatric (HepA)					✔ Indigenous* (QLD, NT, WA, SA)	✔ Indigenous* (QLD, NT, WA, SA)								
Gardasil®9 (HPV)								✔ 2 doses (6 months apart)						
Boostrix® (dTpa)								✔						
Boostrix® or **Adacel®** (dTpa)										✔				
Pneumovax23® (Pneumococcal)							✔ Medically at-risk				✔ Medically at-risk	✔	✔	
Zostavax® (Herpes zoster)														✔**
Annual influenza vaccination	– 6 months and over with certain medical risk factors – All Aboriginal and Torres Strait Islander people 6 months and over – 65 years and over – Pregnant women													

*The term Indigenous is inclusive of Aboriginal and Torres Strait Islander people
** Until 31 October 2021, a catch-up dose is also available for 71 to 79 year olds

All people aged less than 20 years are eligible for free catch up vaccines. | Adult refugees and humanitarian entrants are eligible for free catch up vaccines. | Additional vaccines might be funded by some States and Territories

For more information **visit health.gov.au/immunisation**

OTHER DETAILS

Are there any court orders affecting your child/ren? ☐ Yes ☐ No
(please attach copy)

Please state particulars: .....
.....

Do the Parents /Guardians/child/ren hold a Health Care Card under the Social Security Act? Please provide a copy of the Health Care Card)

☐ Yes ☐ No

Do parents/guardians or child identify as:

☐ Aboriginal
☐ Torres Strait Islander
☐ Aboriginal and Torres Strait Islander
☐ Australian South Sea Islander
☐ Any other Culture (please name) .....

Primary language of the family: .....

Has your child/ren any special cultural or religious requirements? ☐ Yes ☐ No
If yes, please state:
.....
.....
.....

Has your family accessed In Home Care in the past? ☐ Yes ☐ No

Have you applied for the Childcare Subsidy? ☐ Yes ☐ No

What is your approved percentage per fortnight? .....

How many hours have you been approved per fortnight? .....

Have you completed a Family Management Plan? ☐ Yes ☐ No

Do you give permission for your child/ren to be photographed and for photos and videos to be used internally for programming and display purposes? ☐ Yes ☐ No

Do you give permission for your child/ren to be photographed and for photos and videos to be used externally for promotion or publicity purposes? ☐ Yes ☐ No

Do you give permission for your child/ren to be photographed and for photos and videos to be used externally including on Council's website or OutbackLRC app for promotion or publicity purposes?
☐ Yes ☐ No

ELIGIBILITY ASSESSMENT

Local Government Area: ……

State Electoral Area: ……

Federal Electoral Area: ……

EDUCATOR RECRUITMENT

Do you approve for your job advertisement to be advertised on Teach Outback? ☐ Yes ☐ No

Would you like assistance creating a job advertisement? ☐ Yes ☐ No
(If so, please email photos to emilya@longreach.qld.gov.au)

Position Description (brief explanation of your family, location and what your position entails)

……

……

……

……

……

……

Duties you require of an educator:

……

……

……

……

……

……

Will the Educator stay with you or travel to and from the property on a daily/weekly basis?
What accommodation will you provide?

……

……

……

If you are providing board and keep, what is the weekly value? ……

GENERAL INFORMATION

Details of Public Liability Insurance

Name of Insurance Company: ……

Policy Number: …… Expiry Date: ……

EMERGENCY CONTACT AND AUTHORISATION TO COLLECT INFORMATION

If parents cannot be contacted, whom do you wish the Educator to contact in case of emergencies?

Name: ..... Phone Number: .....

Address: .....

Relationship to Child: .....

Authorised to collect ☐ Emergency Contact ☐ Medical Emergency contact ☐

Name: ..... Phone Number: .....

Address: .....

Relationship to Child: .....

Authorised to collect ☐ Emergency Contact ☐ Medical Emergency contact ☐

****

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

****

OFFICE USE ONLY

Immunisations Provided ☐ Yes ☐ No

FMP on File ☐ Yes ☐ No

Service Representative Name: _____ Date: _____

Service Representative Signature: _____