

CLIENT INFORMATION AND AUTHORISATION FORM



Post Office Box 22
Lochinvar NSW 2321
Phone: 1300 875 557
www.kiddicare.com.au

Client's name: _____ Contact Ph: _____

Child's name(s): _____

Child's age(s): _____

In order for us to provide professional, responsible care to your children, we require your written authorisation to permit us to carry out the following functions. Please circle **Yes** or **No** to indicate your permission for your babysitter to:

(a)	Seek immediate medical or dental treatment from any available doctor, dentist, hospital or ambulance service, in the event of a medical emergency	YES / NO
(b)	Administer basic medication to any person under care. (If 'Yes', please provide full details on Medication Form)	YES / NO
(c)	Take the person(s) under care on an excursion or outing (If 'Yes', please specify _____)	YES / NO
(d)	Allow the person(s) under care to participate in water based activities, including swimming in any pool	YES / NO

Other Important Information

Does your child suffer from allergies or have certain special needs?
If **yes**, please record details on the table below:

Child's name	Allergies	Prohibited Foods (NOT to be given)	Special Needs

Signature of
Parent/Guardian: _____ Date: _____