



PARENT/CARER DETAILS

Name of Program: DAYSTAY

Date of Admission ____/____/____

Medicare No: ____/____/____

Number listed on Card (eg 1, 2, 3)

Expiry Date ____/____/____

Mrs / Miss / Ms / Mr Surname: _____

Single

Given names: _____

Married

Date of Birth: _____

Separated

Country of birth: _____ State: _____

Divorced

Address: _____

Defacto

Postcode: _____

Widow

Phone Number: (AH) _____ (BH) _____

Email: _____

Health Care Card No: ____/____/____

Expiry Date: ____/____/____

Language spoken at home: _____

Total number of children _____

FAMILY INCOME: (please tick)

- | | |
|---|---|
| <input type="checkbox"/> Carer pension | <input type="checkbox"/> Newstart / Jobsearch allowance |
| <input type="checkbox"/> Disability support pension | <input type="checkbox"/> Other pension / benefit |
| <input type="checkbox"/> Employed | <input type="checkbox"/> Sole parent pension |
| <input type="checkbox"/> Family Tax Benefit | <input type="checkbox"/> Young homeless allowance |
| <input type="checkbox"/> Family Assistance | |

EMERGENCY CONTACT:

Surname: _____ Given Names: _____

Relationship to Client: _____

Address: _____

Postcode: _____

Phone Number: (BH) _____ (AH) _____

MEDICAL DETAILS:

Doctor's Name: _____

Address: _____

Phone No: _____

PREVIOUS CLIENT:

Have you ever received a service from QEC? YES / NO

CHILD'S DETAILS (1)

Medicare No: ____/____/____ Expiry Date ____/____/____ Number listed on Card (eg 1,2,3)

Surname: _____

Given names: _____ Male Female

Date of Birth: _____ Country of birth: _____ State: _____

Is your child talking? Yes No If yes, language spoken at home: _____

CHILD'S DETAILS (2)

Medicare No: ____/____/____ Expiry Date ____/____/____ Number listed on Card (eg 1,2,3)

Surname: _____

Given names: _____ Male Female

Date of Birth: _____ Country of birth: _____ State: _____

Is your child talking? Yes No If yes, language spoken at home: _____

FATHER'S/SUPPORT PERSON DETAILS

Medicare No: ____/____/____ Expiry Date ____/____/____ Number listed on Card (eg 1,2,3)

Surname: _____

Single

Given names: _____

Married

Date of Birth: _____

Separated

Country of birth: _____ State: _____

Divorced

Address: _____

Defacto

Postcode: _____

Widow

Phone Number: (AH) _____ (BH) _____

Language spoken at home: _____

Health Care Card No: ____/____/____ Expiry Date: ____/____/____

ABORIGINALITY:

Please tick correct one:

- Not Indigenous – Not Aboriginal or Torres Strait Islander origin
- Indigenous – Aboriginal but not Torres Strait Islander origin
- Indigenous – Torres Strait Islander but not Aboriginal origin
- Indigenous – Aboriginal and Torres Strait Islander origin