

**Vietnamese Groups WEST** **Enrolment Application Form Private and Confidential**

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| **PART A General Referral and Consent** | | | | | | |
| Date this form is being completed | | | | |  | |
| What is the name of person completing this form? | | | | |  | |
| What is the relationship between the person completing this form and the person being referred to participate in our programs? | | | | |  | |
| What is the referrer’s contact telephone number? | | | | |  | |
| If the referrer is a participant or their parent, do you provide your consent for the information in this form to given to us and stored privately and confidentially? | | | | | YES /NO | |
| If the referrer is service provider or other community member, has the participant and their parent given you their consent to complete this form on their behalf? | | | | | YES /NO | |
| **PART B Basic details of the Family** | | | | | | |
| Parent/Carer Full Name: |  | Relationship of this Person to the Participating Child/Children: | |  | | |
| Address: |  | | Parent/Carer Date of Birth: |  | | |
| Parent/Carer Contact Details: | Home Phone: | Mobile Number: | | Email Address: | | |
| Languages spoken by the Parent/Carer |  | Is an Interpreter required? | YES/No | Details: | | |
| Does the Parent/Carer have Aboriginal or TSI heritage? | YES/No | What is the Parent/Carer’s Country of Birth? |  | What is the Parent/Carer’s Cultural Identity? | |  |
| Emergency Contact Details for the Family and child/ren covered in this form | Full Name: | Relationship of the Emergency Contact to the Participating Child/Children: | | Mobile: | | Email: |
| What is the Name of Participating Child/Children/Youth with a disability from your family covered in this Enrolment Form | Child/Youth Number 1: | Is child/Youth 1 of Aboriginal or TSI heritage? | YES /No | What is child/youth Number 1’s Birth Country? | |  |
| Child/youth Number 2: | Is child/Youth 2 of Aboriginal or TSI heritage? | YES /No | What is child/youth Number 2’s Birth Country? | |  |
| Child/Youth Number 3: | Is child/Youth 3 of Aboriginal or TSI heritage? | YES /No | What is child/youth Number 3’s Birth Country? | |  |

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| **Part C Details of Participating Child/Youth 1 COMPLETE THIS SECTION IF YOU HAVE ONLY ONE CHILD with a disability WISHING TO PARTICIPATE IN PROGRAMS** | | | | | | | | | | | | | | | | | |
| Full Name |  | | | Birthdate |  | | | Sex | |  | | | Gender Identification | | |  | |
| Address |  | | | | Mobile (if any) | | |  | | | | | Email (if any) | | |  | |
| Languages spoken by the participant |  | | | | Is an Interpreter required? | | | YES/No | | Details: | | | | | | | |
| Please circle all program/s the Participating Child/ Youth in your family would like to take part in | | | | Ket Noi Brimbank Vươn lên Tham Gia Family Tham Gia Primary Tham Gia Secondary Tham Gia Explorer | | | | | | | | | | | | | |
| Does the participant have a NDIS Plan? | YES /No | | **Plan Number:**  **Expiry Date:** | | | | | Does the participant have a Companion or Concession Card? | | | | | Companion: YES /No | | | | |
| Concession: YES /No | | | | |
| What is the participant’s primary disability | | | |  | | | | | | | | | | | | | |
| Does the participant’s experience any secondary disabilities? | | | |  | | | | | | | | | | | | | |
| Does the participant’s experience any health, medical illnesses, or psycho-social issues? | | | |  | | | | | | | | | | | | | |
| Does the participant’s experience any allergies? | | | | (Please provide details of any allergies and how they are managed) | | | | | | | | | | | | | |
| Who is the participant’s general practitioner doctor? | | | | Name:  Clinic Address and Telephone: | | | | | | | | | | | | | |
| Which days and times is the participant available to join in program activities? | | | | **Please tick times when Available to Participate** | | **Mon** | **Tues** | | **Wed** | | **Thurs** | **Fri** | | **Sat** | **Sun** | | **Comments** |
|  |  | |  | |  |  | |  |  | |  |
| Does the participant have any hobbies or special interests? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Does the participant have any specific goals in taking part in these programs? | | | | YES /No | (Please provide details – for example – you might want to get involved in a community club; learn new skills or make new friends) | | | | | | | | | | | | |
| Is the participant currently attending school, day program, TAFE or university studies? | | | | YES /No | (Please provide details including year level) | | | | | | | | | | | | |
| Is the participant involved in any regular community-based activities **currently**? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Has the participant been involved in any community-based activities or school holiday program **in the past**? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Has the participant ever experienced difficulties in taking part in community activities or school holiday programs in the past? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Can you identify any factors that have made it difficult for the participant to be more involved in community activities? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Does the participant have any specific mobility or personal care support needs (for example with hygiene and toileting)? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Does the participant experience any difficulties verbal or non-verbal communication? | | | | YES /No | (Please provide details including information about any communication aides or devices if used) | | | | | | | | | | | | |
| Does the participant feel comfortable interacting with new people? | | | | YES /No | What techniques could help them be comfortable with new people? | | | | | | | | | | | | |
| Do you feel the participant experiences a sense of social isolation in their life? | | | | YES /No | Details. Please describe the level and impact of social isolation you feel the participant is currently experiencing | | | | | | | | | | | | |
| Does the participant have any specific dietary support requirements we should be aware of? | | | | YES /No | Details: Please describe specific dietary support needs and if the participant has any swallowing difficulties | | | | | | | | | | | | |
| Does the participant have any specific cultural or religious observances we should be aware of | | | | YES /No | Details: | | | | | | | | | | | | |
| Does the participant have any of the following Plans in place?  **Note: The program will require a copy of any Plans prior to participation** | | Asthma Emergency Plan | | YES /No | Details: | | | | | | | | | | | | |
| Epilepsy Emergency Plan | | YES /No | Details: | | | | | | | | | | | | |
| Other Medical Emergency Plan | | YES /No | Details: | | | | | | | | | | | | |
| Behavior Support Plan | | YES /No | Details: | | | | | | | | | | | | |
| Is the participant likely to require support from program staff to take medication? | | | | YES /No | If yes, please provide a list of medications the participant takes (Note that written authority from the participant’s doctor and parent is required before staff can assist with medications) | | | | | | | | | | | | |
| Are there any activities the participant does not enjoy or should avoid doing? | | | | YES /No | Details: | | | | | | | | | | | | |
| Has the participant ever experienced difficult behaviors before (examples might be melt-downs, aggression towards others or feeling very anxious)? | | | | YES /No | Details: | | | | | | | | | | | | |
| If the participant has experienced difficult behaviors what tends to trigger these behaviors? | | | | YES /No | Details: | | | | | | | | | | | | |
| Are there any steps you take to manage difficult behaviors if they occur? | | | | YES /No | Details: | | | | | | | | | | | | |
| Does the participant have any tendency to become distracted and wander away on their own? | | | | YES /No | Please provide details of when this might happen and the steps you take to maintain safety: | | | | | | | | | | | | |
| Do you have any other relevant information about your child that you feel we should be aware of to ensure their safety during participation in programs? | | | | YES /No | Details. Please include any relevant family or custodial issues we may need to be made aware of | | | | | | | | | | | | |
| Do you have any questions about the programs you have selected and your child’s participation in these programs? | | | | YES /No | Details: | | | | | | | | | | | | |
| **Part D Details of Participating Child/Youth 2 Only COMPLETE THIS SECTION IF YOU HAVE more than one child with a disability WISHING TO PARTICIPATE IN PROGRAMS** | | | | | | | | | | | | | | | | | |
| Full Name |  | | | Birthdate |  | | | Sex | |  | | | Gender Identification | | |  | |
| Address |  | | | | Mobile (if any) | | |  | | | | | Email (if any) | | |  | |
| Languages spoken by the participant |  | | | | Is an Interpreter required? | | | YES/No | | Details: | | | | | | | |
| Please circle all program/s the Participating Child/ Youth in your family would like to take part in | | | | Ket Noi Brimbank Vươn lên Tham Gia Family Tham Gia Primary Tham Gia Secondary Tham Gia Explorer | | | | | | | | | | | | | |
| Does the participant have a NDIS Plan? | YES /No | | **Plan Number:**  **Expiry Date:** | | | | | Does the participant have a Companion or Concession Card? | | | | | Companion: YES /No | | | | |
| Concession: YES /No | | | | |
| What is the participant’s primary disability | | | |  | | | | | | | | | | | | | |
| Does the participant’s experience any secondary disabilities? | | | |  | | | | | | | | | | | | | |
| Does the participant’s experience any health, medical illnesses or psycho-social issues? | | | |  | | | | | | | | | | | | | |
| Does the participant’s experience any allergies? | | | | (Please provide details of any allergies and how they are managed) | | | | | | | | | | | | | |
| Who is the participant’s general practitioner doctor? | | | | Name:  Clinic Address and Telephone: | | | | | | | | | | | | | |
| Which days and times is the participant available to join in program activities? | | | | **Please tick times when Available to Participate** | | **Mon** | **Tues** | | **Wed** | | **Thurs** | **Fri** | | **Sat** | **Sun** | | **Comments** |
|  |  | |  | |  |  | |  |  | |  |
| Does the participant have any hobbies or special interests? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Does the participant have any specific goals in taking part in these programs? | | | | YES /No | (Please provide details – for example – you might want to get involved in a community club; learn new skills or make new friends) | | | | | | | | | | | | |
| Is the participant currently attending school, day program, TAFE or university studies? | | | | YES /No | (Please provide details including year level) | | | | | | | | | | | | |
| Is the participant involved in any regular community-based activities **currently**? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Has the participant been involved in any community-based activities or school holiday program **in the past**? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Has the participant ever experienced difficulties in taking part in community activities or school holiday programs in the past? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Can you identify any factors that have made it difficult for the participant to be more involved in community activities? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Does the participant have any specific mobility or personal care support needs (for example with hygiene and toileting)? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Does the participant experience any difficulties verbal or non-verbal communication? | | | | YES /No | (Please provide details including information about any communication aides or devices if used) | | | | | | | | | | | | |
| Does the participant feel comfortable interacting with new people? | | | | YES /No | What techniques could help them be comfortable with new people? | | | | | | | | | | | | |
| Do you feel the participant experiences a sense of social isolation in their life? | | | | YES /No | Details. Please describe the level and impact of social isolation you feel the participant is currently experiencing | | | | | | | | | | | | |
| Does the participant have any specific dietary requirements we should be aware of? | | | | YES /No | Details: | | | | | | | | | | | | |
| Does the participant have any specific cultural or religious observances we should be aware of | | | | YES /No | Details: | | | | | | | | | | | | |
| Does the participant have any of the following Plans in place?  **Note: The program will require a copy of any Plans prior to participation** | | Asthma Emergency Plan | | YES /No | Details: | | | | | | | | | | | | |
| Epilepsy Emergency Plan | | YES /No | Details: | | | | | | | | | | | | |
| Other Medical Emergency Plan | | YES /No | Details: | | | | | | | | | | | | |
| Behavior Support Plan | | YES /No | Details: | | | | | | | | | | | | |
| Is the participant likely to require support from program staff to take medication? | | | | YES /No | If yes, please provide a list of medications the participant takes (Note that written authority from the participant’s doctor and parent is required before staff can assist with medications) | | | | | | | | | | | | |
| Are there any activities the participant does not enjoy or should avoid doing? | | | | YES /No | Details: | | | | | | | | | | | | |
| Has the participant ever experienced difficult behaviors before (examples might be melt-downs, aggression towards others or feeling very anxious)? | | | | YES /No | Details: | | | | | | | | | | | | |
| If the participant has experienced difficult behaviors what tends to trigger these behaviors? | | | | YES /No | Details: | | | | | | | | | | | | |
| Are there any steps you take to manage difficult behaviors if they occur? | | | | YES /No | Details: | | | | | | | | | | | | |
| Does the participant have any tendency to become distracted and wander away on their own? | | | | YES /No | Please provide details of when this might happen and the steps you take to maintain safety: | | | | | | | | | | | | |
| Do you have any other relevant information about your child that you feel we should be aware of to ensure their safety during participation in programs? | | | | YES /No | Details. Please include any relevant family or custodial issues we may need to be made aware of | | | | | | | | | | | | |
| Do you have any questions about the programs you have selected and your child’s participation in these programs? | | | | YES /No | Details: | | | | | | | | | | | | |
| **Part E Details of Participating Child/Youth 3 ONLY COMPLETE THIS SECTION IF YOU HAVE MORE THAN Two CHILDREN WITH A DISABILITY PARTICIPATING** | | | | | | | | | | | | | | | | | |
| Full Name |  | | | Birthdate |  | | | Sex | |  | | | Gender Identification | | |  | |
| Address |  | | | | Mobile (if any) | | |  | | | | | Email (if any) | | |  | |
| Languages spoken by the participant |  | | | | Is an Interpreter required? | | | YES/No | | Details: | | | | | | | |
| Please circle all program/s the Participating Child/ Youth in your family would like to take part in | | | | Ket Noi Brimbank Vươn lên Tham Gia Family Tham Gia Primary Tham Gia Secondary Tham Gia Explorer | | | | | | | | | | | | | |
| Does the participant have a NDIS Plan? | YES /No | | **Plan Number:**  **Expiry Date:** | | | | | Does the participant have a Companion or Concession Card? | | | | | Companion: YES /No | | | | |
| Concession: YES /No | | | | |
| What is the participant’s primary disability | | | |  | | | | | | | | | | | | | |
| Does the participant’s experience any secondary disabilities? | | | |  | | | | | | | | | | | | | |
| Does the participant’s experience any health, medical illnesses or psycho-social issues? | | | |  | | | | | | | | | | | | | |
| Does the participant’s experience any allergies? | | | | (Please provide details of any allergies and how they are managed) | | | | | | | | | | | | | |
| Who is the participant’s general practitioner doctor? | | | | Name:  Clinic Address and Telephone: | | | | | | | | | | | | | |
| Which days and times is the participant available to join in program activities? | | | | **Please tick times when Available to Participate** | | **Mon** | **Tues** | | **Wed** | | **Thurs** | **Fri** | | **Sat** | **Sun** | | **Comments** |
|  |  | |  | |  |  | |  |  | |  |
| Does the participant have any hobbies or special interests? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Does the participant have any specific goals in taking part in these programs? | | | | YES /No | (Please provide details – for example – you might want to get involved in a community club; learn new skills or make new friends) | | | | | | | | | | | | |
| Is the participant currently attending school, day program, TAFE or university studies? | | | | YES /No | (Please provide details including year level) | | | | | | | | | | | | |
| Is the participant involved in any regular community-based activities **currently**? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Has the participant been involved in any community-based activities or school holiday program **in the past**? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Has the participant ever experienced difficulties in taking part in community activities or school holiday programs in the past? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Can you identify any factors that have made it difficult for the participant to be more involved in community activities? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Does the participant have any specific mobility or personal care support needs (for example with hygiene and toileting)? | | | | YES /No | (Please provide details) | | | | | | | | | | | | |
| Does the participant experience any difficulties verbal or non-verbal communication? | | | | YES /No | (Please provide details including information about any communication aides or devices if used) | | | | | | | | | | | | |
| Does the participant feel comfortable interacting with new people? | | | | YES /No | What techniques could help them be comfortable with new people? | | | | | | | | | | | | |
| Do you feel the participant experiences a sense of social isolation in their life? | | | | YES /No | Details. Please describe the level and impact of social isolation you feel the participant is currently experiencing | | | | | | | | | | | | |
| Does the participant have any specific dietary requirements we should be aware of? | | | | YES /No | Details: | | | | | | | | | | | | |
| Does the participant have any specific cultural or religious observances we should be aware of | | | | YES /No | Details: | | | | | | | | | | | | |
| Does the participant have any of the following Plans in place?  **Note: The program will require a copy of any Plans prior to participation** | | Asthma Emergency Plan | | YES /No | Details: | | | | | | | | | | | | |
| Epilepsy Emergency Plan | | YES /No | Details: | | | | | | | | | | | | |
| Other Medical Emergency Plan | | YES /No | Details: | | | | | | | | | | | | |
| Behavior Support Plan | | YES /No | Details: | | | | | | | | | | | | |
| Is the participant likely to require support from program staff to take medication? | | | | YES /No | If yes, please provide a list of medications the participant takes (Note that written authority from the participant’s doctor and parent is required before staff can assist with medications) | | | | | | | | | | | | |
| Are there any activities the participant does not enjoy or should avoid doing? | | | | YES /No | Details: | | | | | | | | | | | | |
| Has the participant ever experienced difficult behaviors before (examples might be melt-downs, aggression towards others or feeling very anxious)? | | | | YES /No | Details: | | | | | | | | | | | | |
| If the participant has experienced difficult behaviors what tends to trigger these behaviors? | | | | YES /No | Details: | | | | | | | | | | | | |
| Are there any steps you take to manage difficult behaviors if they occur? | | | | YES /No | Details: | | | | | | | | | | | | |
| Does the participant have any tendency to become distracted and wander away on their own? | | | | YES /No | Please provide details of when this might happen and the steps you take to maintain safety: | | | | | | | | | | | | |
| Do you have any other relevant information about your child that you feel we should be aware of to ensure their safety during participation in programs? | | | | YES /No | Details. Please include any relevant family or custodial issues we may need to be made aware of | | | | | | | | | | | | |
| Do you have any questions about the programs you have selected and your child’s participation in these programs? | | | | YES /No | Details: | | | | | | | | | | | | |