REGISTRATION FORM

Please fill in this form and email it to kaahoots@outlook.com

Participant Details						
First Name			Surname			
Date of Birth			Gender	M ☐	F ☐	Other ☐
Home Phone			Mobile			
Email						
Address						
Living with	Parent(s) and sibling(s) ☐	Parent(s) ☐	With relatives ☐	Other:		
Country of Birth			Language/s spoken			
Main Cultural Identity			Second Cultural Identity			
Do you identify as Indigenous?	No ☐	Yes, Aboriginal ☐	Yes, Torres Strait Islander ☐	Yes, South Sea Islander ☐		
Education *(please tick highest level of education)*						
No education ☐	Attending Pre-Primary ☐		Attending Primary ☐	Completed Year 9 ☐		
Completed Year 10 ☐	Completed Year 11 ☐		Completed Year 12 ☐	Diploma ☐		
Bachelor Degree ☐	Master Degree ☐		PhD/Higher ☐	Other:		
Name of current school / childcare			Teacher			
Medical						
Medicare Card			Reference		Expiry	
HealthCare Card					Expiry	
Are there any allergies or medical conditions we should be aware of? *(please give details)*						
Emergency Contacts						
Full Name			Relationship			
Home Phone			Mobile			
Full Name			Relationship			
Home Phone			Mobile			

Disclosure of Liability of Healthcare and Parental Authority for the Treatment of a Minor
(not applicable if participant is over 18 years old)

I, _____, declare that I am legally responsible to make the decisions about the health and wellbeing of _____, date of birth _____ and with this legal responsibility, give KaaHoots Therapeutic Services (KTS) permission to establish a treatment plan for the benefit of my child's health and wellbeing.

KaaHoots only requires the consent of one parent per child, in particular when providing services to children of separated parents. The consent of either parent is sufficient authority for a doctor or other health professional to undertake on a child a clinically indicated medical procedure, from a routine examination to complex surgery. Parents are also entitled to refuse treatment that a doctor recommends, or choose alternative treatment.

Consent to Share Information			
The people and services that I agree to share my information with are:			
Family/Carer Name			
GP Name		Medical Centre	
Paediatrician		Location	
School/Childcare		Teacher	
Other service provider		Location	
*The people and services that I **do not** agree to share my/my child's information with are*			

☐	*I understand and accept that by signing this agreement I give consent to KaaHoots Therapeutic Services (KTS) to receive and share my personal information when relevant to my care*
☐	*I understand and have read the Privacy and Confidentiality Information Sheet – how my information will be collected and used*
☐	*I am confident that I understand the information and conditions described in this form*

Name		Relationship to Child (if applicable)	
Signature		Date	