

COOTAMUNDRA PRESCHOOL WAITING LIST APPLICATION

CHILD'S NAME: _____

D.O.B: _____ 3 OR 4/5 YR OLD GROUP (CIRCLE)

PARENT/GUARDIAN: _____

ADDRESS: _____

PH: H _____ W _____ M _____

PREFERRED DAY/S:

MON TUE WED THU FRI

PREFERRED START DATE: TERM _____ YEAR _____

PRIORITY OF ACCESS

Please answer the following questions to assess your Priority of Access rating, as determined by the NSW Governments Early Childhood Services Policy.

1. Is your child at risk of harm? Please specify: _____

2. Is your child of Aboriginal or Torres Strait Islander descent? Yes/No
3. Is your child from a diverse cultural background? Yes/No
Please specify: _____
4. Do you or your child have a continuing disability? Yes/No
Please specify: _____
5. Is your combined income under 20,355/year? Yes/No
6. Are you living in isolated circumstances? Yes/No

I declare that the information on this form is correct and true.

Signature: _____ Date: _____

Preschool to complete: Priority of Access rating _____

Day/s Offered: MON TUE WED THU FRI

Date: _____

