CONFIDENTIAL: RESTRICTED ACCESS

☐ Full Enrolment ☐ Casual Enrolment

Belair Primary School OSHC
Enrolment Form: Part 1
2018

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CHILD

Family Name: | Gender: F / M

First Name(s): | Known as:

Date of birth: _ _ / _ _ / _ _ _ _ | CRN:

Address No. / Street: | Town/ Suburb:

Postcode: | Primary Language:

Indigenous status: | Aboriginal: Yes / No | TS Islander: Yes / No

ENROLLING PARENT/GUARDIAN & BILLING DETAILS

Name:

Date of birth: _ _ / _ _ / _ _ _ _ | CRN:

Relationship to child: | Contact Priority: ☐ | Primary Language:

Address: (h)

(w)

Phone: (h) | (w) | (m)

Email:

IN CARE ELSEWHERE

I am claiming Childcare Benefit at other Approved Childcare Service/s (which includes LDC,OSHC,FDC,IHC,OCC) for this number of children: ☐

OTHER PARENT/GUARDIAN (if applicable)

Name:

Relationship to child: | Contact Priority: ☐ | Primary Language:

Address: (h)

(w)

Phone: (h) | (w) | (m)

Email:

PARENTING PLANS / ORDERS relating to this child

EMERGENCY CONTACTS & COLLECTION AUTHORITIES

Name: | Contact Priority: ☐

Address: | Relationship to child:

Phone: (h) | (w) | (m)

Name: | Contact Priority: ☐

Address: | Relationship to child:

Phone: (h) | (w) | (m)

N.B. It is very important that you tell these people that you have nominated them. In nominating them you give them authority to act on the child's behalf if neither parent can be located, to pick up the child in an emergency and care for the child until s/he can be returned home.

COLLECTION AUTHORITIES ONLY

Name:

Address: | Relationship to child:

Phone: (h) | (w) | (m)

Name:

Address: | Relationship to child:

Phone: (h) | (w) | (m)

N.B. The people nominated here have been given approval only to collect the child and should NOT be contacted in case of an emergency.

Enrolment Form: Part 2

Child's Name:

MEDICAL AND HEALTH INFORMATION

Has the child received all immunisations appropriate for her/his age? Yes / No

If no, please give details:

Has the child received the following immunisations? (please tick):

	10 - 15 years
Hepatitis B	☐
Diphtheria	☐
Tetanus	☐
Pertussis (Whooping Cough)	☐
Varicella (Chickenpox)	☐
Human Papillomavirus (HPV)	☐

I accept full responsibility if my child is not immunised.

Parent / Guardian signature:

Has the child any conditions / medications that may be effected by OSHC activities?

If yes, please give specifics and any related medication:

Has the child any disabilities? Yes / No **Effective date:** _ _ /_ _ /_ _ _ _

If yes, please record specifics:

Has the child any special needs? Yes / No **Effective date:** _ _ /_ _ /_ _ _ _

If yes, please record specifics:

Does the child usually require special aids (e.g. glasses, hearing aid etc.)?

If yes, please give details:

Has the child any special dietary needs not related to allergies?

If yes, please give specifics:

Has the child suffered any illness that may re-occur (e.g. chronic ear infection)?

If yes, please give details:

Has the child had any kind of allergic reactions or food intolerances?

Foods:	Reaction / Medication:

Penicillin:	Reaction / Medication:

Others:	Reaction / Medication:

Is there any other medical information we might need to know?

Note: Please supply the service with required medications in original containers with the child's name clearly marked. Please complete a permission to administer medication form together with any medication records where necessary.

Usual Medical attendant

Doctor's name: **Phone No.:**

Clinic name:

Address:

Usual Dental attendant

Dentist's name: **Phone No.:**

Clinic name:

Address:

Medical Benefits cover with:

Ambulance cover with:

Medicare number: **Health Care Card number:**

Enrolment Form: Part 3

Child's Name:

BOOKINGS

BSC	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Arrive:							
Depart:							

From: __/__/____ for: ____ weeks / or until: __/__/____ or Ongoing (tick) ☐

ASC	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Arrive:							
Depart:							

From: __/__/____ for: ____ weeks / or until: __/__/____ or Ongoing (tick) ☐

VAC	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Arrive:							
Depart:							

From: __/__/____ for: ____ weeks / or until: __/__/____ or Ongoing (tick) ☐

IS THERE ANYTHING MORE WE NEED TO KNOW?

(e.g. 1. any personal, religious or cultural practices/prohibitions that you would like the service to know or 2. comments on homework, behaviour management etc.)

CONSENTS

Please initial next to each item to which you consent.

I have supplied the service with a copy of the Centre-link Assessment Notice of Child Care Benefit for approved care. ____

I have supplied the service with my email address, contact numbers, home address and will update the service if any changes occur. ____

I agree to pay the required fees for my child or children's care by the end of the invoice week in accordance with the Service Fee Policy ____

I agree to provide the service with a copy of the 'Child Health Record' update. ____

I give permission for the OSHC Director or Assistant Director to exchange information relating to my child or children with educators and other relevant professionals. I understand that this information will be confidential. ____

I agree to the Late Collection Fee Policy and understand that I am responsible for collecting my child or children by 6:00pm. If I am unable to I will arrange for someone on my contact list with collection authority to do so. ____

I give consent for my child or children to participate in supervised bus excursions as part of the program. ____

I consent to my child or children's photo/video being published in the OSHC newsletter, on the See Saw Learning Journal application and displayed in the OSHC room. ____

AGREEMENTS

I agree to pay the required fees for my child's booked childcare hours and accept the policies and rules of the Service.

I agree that the staff of the Service may administer simple first aid to my child if the need arises.

I understand that if at any time the staff of the Service consider that my child requires emergency medical/hospital/ambulance assistance, they will have the local medical/ hospital/ambulance attend my child. I acknowledge that I will be liable for any medical/ hospital/ambulance expenses incurred in the treatment of my child.

I certify that the information entered upon this form is true to the best of my knowledge and I undertake to inform the Service if any of these details change.

Parent / Guardian signature: _____ **Date:** __/__/____

sighted a child health record (tick) ☐

Interviewed / Accepted by: _____ **Date:** __/__/____