CONFIDENTIAL: RESTRICTED ACCESS

☐ Flexible / Casual ☐ Fixed / Routine

Belair Primary School OSHC
Enrolment Form: Part 1

45-83 Main Road, Belair SA 5052, AU
Ph: 8278 7609

** 2025**

belair.oshc537@schools.sa.edu.au

CHILD

Family Name: | Gender:

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

ELIGIBLE PARENT/GUARDIAN & BILLING DETAILS

Name:

Date of birth: __ / __ / ____ | CRN:

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

Address: (h)

(w)

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

Email:

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 their age? Yes / No

If no, please give details:

I accept full responsibility if my child is not immunised.

Parent / Guardian signature:

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

	12 - 13 years
Diphtheria	☐
Tetanus	☐
Pertussis (Whooping Cough)	☐
Human Papillomavirus (HPV)	☐

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 given the service a copy of the Centrelink Child Care Subsidy Assessment notice (new enrolments) and an updated copy of my child's Medical Management Plan (children with medical conditions only). ☐

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

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

I agree to abide by the service's Late Collection Fee Policy and understand that I am responsible for collecting my child by 6.00pm. If I am unable to do so, I will arrange for someone on my contact list with collection authority to do so. ☐

I consent to my child watching movies rated PG. All movies will be viewed by staff before being shown to children. ☐

I have read the OSHC policies on the school website, including the Cancellation Policy. I agree to comply with the service's policies and procedures. ☐

I agree to pay the required fees for my child's care by the end of the invoice week in accordance with the service's Fee Policy. ☐

I consent to my child/ren's photo/video being 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:** _ _ / _ _ / _ _ _ _