CONFIDENTIAL: RESTRICTED ACCESS

☐ Casual Enrolment:
☐ Full Enrolment:

# Out of Hours Care - Norton Summit

# Enrolment Form: Part 1

Norton Summit Primary School
Crescent Drive NORTON SUMMIT
5136
8390 1771

## CHILD

Family Name: ____ Gender: F / M

First Name(s): ____ Known as: ____

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

Address No. / Street: ____

Town/Suburb: ____ Postcode: ____

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

## ENROLLING PARENT/GUARDIAN & BILLING DETAILS

Name: ____

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

Relationship to child: ____ Contact Priority: ☐

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: ☐

Address: (h) ____
(w) ____

## 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) ____

Printed: 06/08/2010 03:50

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# 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 - 13 years | 12 - 18 years |
|---|---|---|
| Hepatitis B | ☐ | |
| 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?

| 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:



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# 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 consent for my child to take part in supervised walks/visits to a local park/ playground/shop as part of the OSHC programme. ☐

I understand it is my responsibility to advise staff if I do not wish my child/ren to participate in a particular activity. ☐

I consent for a staff member to apply sunblock/ insect repellant if required. ☐

My child/ren has permission to be transported in a private vehicle if deemed necessary by the co-ordinator and in accordance with OSHC standards. ☐

I give consent for my child to be taken by a staff member to the local hospital or doctor's surgery in the event of a minor injury. Any ambulance costs will be paid by the parent. ☐

Photographs of my child/ren taken while at the service may be used for display purposes in the OSHC room and will not be used on the web. ☐

I give permission for OSHC staff to exchange information relating to my child with school staff and to the appropriate person(s). I understand that this information will be handled confidentially. ☐

## 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: __/__/____

Interviewed / Accepted by: ____________________ Date: __/__/____



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