East Para Primary School

OUT OF SCHOOL HOURS CARE
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RATED EXCEEDING NATIONAL QUALITY STANDARD

ENROLMENT FORM

Family Name: _____

Child's Name: _____ Sex ____ D.O.B. _____

Child's Name: _____ Sex ____ D.O.B. _____

Child's Name: _____ Sex ____ D.O.B. _____

Address: _____

_____ Postcode: _____

Does child/ren have a disability? ❑ Yes ❑ No

If yes, tick special category for each child with a disability.

❑ Sensory ❑ Syndrome ❑ Disability
❑ Physical ❑ Speech and Language ❑ Emotional/ Behavioural
❑ Medical Condition ❑ Multiple Disability ❑ Special Needs of the Family

Main reason for child/ren using this service (please tick those that are applicable):

❑ Respite Purposes ❑ Parent Disability ❑ Other
❑ Single Parent Working ❑ Both Parents Working ❑ Negligence or Danger of Abuse
❑ Single Parent Studying ❑ Both Parents Studying ❑ One Parent Working, One Studying

Are children Aboriginal/Torres Strait Islanders? ❑ Yes ❑ No

Enrolling Parent/Guardian 1: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss.

Name: _____ Date of Birth: _____

Address: _____

Country of Birth: _____

Language Spoken at home: _____

Occupation: _____

Place of Employment/Study: _____

Home Phone.: _____ Work Phone: _____ Mobile: _____

Email: _____

Parent/Guardian 2: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss.

Name: _____ Date of Birth: _____

Address: (If different from Above) _____

Country of Birth: _____

Language Spoken at home:: _____

Occupation: _____

Place of Employment/Study _____

Home Phone _____ Work Phone _____ Mobile: _____

Emergency Contact and Collection Authority

1. Name: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Relationship to child: ❑ Guardian ❑ Sister ❑ Aunt ❑ Uncle ❑ Grandparent
❑ Friend ❑ Brother ❑ Neighbour ❑ Other

❑ **Emergency Contact** ❑ **Collection**

2. Name: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Relationship to child: ❑ Guardian ❑ Sister ❑ Aunt ❑ Uncle ❑ Grandparent
❑ Friend ❑ Brother ❑ Neighbour ❑ Other _____

❑ **Emergency Contact** ❑ **Collection**

3. Name: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Relationship to child: ❑ Guardian ❑ Sister ❑ Aunt ❑ Uncle ❑ Grandparent
❑ Friend ❑ Brother ❑ Neighbour ❑ Other _____

❑ **Emergency Contact** ❑ **Collection**

No child will be allowed to leave the program without adult supervision unless written permission is provided by parent/guardian. Children must be signed in and out by parent/ guardian. Drivers License may be required upon collection, if adult not known to staff.

I am aware of the arrival and pick-up procedures for my child/ren at this program.

Signed: _____ Parent/Guardian Date: _____

I give my authority for my children to go with staff on short walking excursions as part of the Out of School Hours Care Program.

Signed: _____ Parent/Guardian Date: _____

I give authority for the name and/or photograph of my child to be published by the media in circumstances that the Director considers appropriate.

Signed: _____ Parent/Guardian Date: _____

Custody: Please complete if parents are separated/divorced and custody is an issue for the family:

Does the child have contact with the other parent? _____

Is anyone legally denied access to the child? _____

Are there any custody orders in place? _____

Any other information? _____

MEDICAL HEALTH INFORMATION

Doctor's Name: _____ Clinic's Name: _____

Address: _____

_____ Phone: _____

Have any of the children any physical limitations or medical conditions?

(eg Asthma, Epilepsy, and the treatment required in an emergency).

Child's Name _____ Condition _____

Child's Name _____ Condition _____

Child's Name _____ Condition _____

Are the children undergoing any treatment or medication?

(Please also include child's self use of medication for treatment and/or prevention of asthma. Please notify the Director should this change.)

Child's Name _____ Treatment / Medication _____

Child's Name _____ Treatment / Medication _____

Child's Name _____ Treatment / Medication _____

Are the children currently immunised against:

Whooping Cough	❑ Yes	❑ No	Diphtheria	❑ Yes	❑ No	Mumps	❑ Yes	❑ No
Polio	❑ Yes	❑ No	Measles	❑ Yes	❑ No	HIB	❑ Yes	❑ No
Rubella	❑ Yes	❑ No	Hepatitis B	❑ Yes	❑ No	Other		
Tetanus	❑ Yes	❑ No		Date of last injection.				

Have the children Allergies of any kind? (Food, Penicillin, Bee Stings).

1. Child's Name _____

Food _____ Reaction _____

Penicillin _____ Reaction _____

Other _____ Reaction _____

2. Child's Name _____

Food _____ Reaction _____

Penicillin _____ Reaction _____

Other _____ Reaction _____

3. Child's Name _____

Food _____ Reaction _____

Penicillin _____ Reaction _____

Other _____ Reaction _____

Have the children suffered any illnesses that may reoccur?

(eg Chronic Infection).

_____

_____

Any other information relevant to your child/ren (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.)

_____

_____

_____

_____

_____

_____

MEDICAL ATTENTION IN CASE OF ACCIDENT OR EMERGENCY

In the event of my child receiving injuries requiring urgent medical treatment, I authorise the care providers and staff to obtain medical assistance they deem necessary, and agree to pay all medical and transport costs incurred on behalf of my child. Once emergency procedures have been enacted all efforts will be made to inform parents.

I further authorise qualified practitioners to administer anaesthetic if the need arises:

Name in full (Block Print) _____

Signature _____ Date _____

Medicare Number _____

Private Health Insurance _____

Ambulance Cover _____

Health Care Card or Pension Card Yes ❑

Health Care Card Number_____ No ❑ Expiry Date _____

Child Care Benefit / Fees

I understand that it is my responsibility to apply for Child Care Benefit through Cenrelink / FAO and that no rebate can be applied to my account until notification of eligibility and the percentage applicable has been received by the staff of East Para Primary OSHC. I understand that all fees are to be paid weekly to the staff of East Para Primary OSHC.

Name in full (Block Print) _____

Signature _____ Date _____

Family CRN:_____

Child 1 CRN: _____ Child name:_____

Child 2 CRN _____ Child name:_____

Child 3 CRN: _____ Child name:_____

Child 4 CRN:_____ Child name:_____

Please note accounts will be sent via Email.