Reynella OSHC & Vacation Care
55-63 Concord Drive
OLD REYNELLA SA 5161

2016 Enrolment Form Part 1

Phone: 8387 7483
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CONFIDENTIAL: RESTRICTED ACCESS

CHILD

Family Name: First Name:

Known as: D.O.B.: Sex: **M / F** CRN:

ENROLLING PARENT/GUARDIAN & BILLING DETAILS

Name: Date of Birth:

CRN: Relationship to Child: Contact Priority:

Address:

Phone: (h) (w) (m)

Email: Please email weekly invoices:

Child resides with (Please circle)

Both parents Mother Father Guardian Shared Care

Casual Enrolment

Permanent Enrolment

OTHER PARENT/GUARDIAN (if applicable)

Relationship to child

Name: Contact Priority:

Address:

Phone: (h) (w) (m)

EMERGENCY CONTACTS

Name:

Relationship to Child: Contact Priority:

Phone: (h) (w) (m)

Name:

Relationship to Child: Contact Priority:

Phone: (h) (w) (m)

N.B. it is very important that you tell these people you have nominated them. In nominating them you give them the 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

Name:

Relationship to Child: Contact Priority:

Phone: (h) (w) (m)

Name:

Relationship to Child: Contact Priority:

Phone: (h) (w) (m)

CARE ELSEWHERE

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

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Enrolment Form: Part 2 **Child's Name:**

PARENTING PLANS / ORDERS relating to this child (Please attach a copy)

MEDICAL AND HEALTH INFORMATION

Child's Medicare Number_____

Has the child any kind of allergic reactions? (eg. Foods, penicillin, insect bites, band aids, etc.)

Allergy	Reaction / Medication
1.	
2.	

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

Has the child received all immunisations appropriate for his/her age? **YES / NO**

If no, please give details:

I accept full responsibility if my child is not immunised. Parent / Guardian signature:

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

If yes, please give specifics and any related medications:

Has the child any additional / special needs?

If yes, please give specifics and any related medication (eg. Asthma—Ventolin):

Does the child usually require special aids (eg. Glasses, hearing aid, etc.)?

If yes, please give details:

Has the child any dietary needs not related to allergies?

If yes, please give details:

Has the child suffered any illness that may re-occur (eg. Chronic ear infection)?

If yes, please give details:

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

NOTE: 1. Please supply the service with required medications in original containers with child's name clearly marked. Please complete a permission to administer medication form, together with any medication records where necessary.
2. A permission to administer medication form must be signed by the doctor/parent before medication can be administered by OSHC staff or self-administered by a child over 8 years of age.

Doctor's name: _____ Phone No: _____

Clinic Name: _____

Address: _____

Are there any foods which should be avoided? _____

What are your hopes and dreams for your child/ren? _____

How can we assist in this? _____

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Enrolment Form: Part 3 **Child's Name:**

IS THERE ANYTHING MORE WE NEED TO KNOW?

1. Other languages spoken at home. ……
2. Cultural background……
3. Any personal, religious or cultural practices/prohibitions that you would like the service to know ……
   ……
4. Comments on homework, behaviour management, etc……
   ……

CONSENTS

Please initial next to each item to which you consent.

I consent for my child/ren to participate in the OSHC/Vac Care program and understand that OSHC Educator will notify parents/guardians of each individual excursion. I understand it is my responsibility to advise Educators if I do not wish my child/ren to participate in a particular activity. ☐

I consent to photographs (still or video) being taken of my child/ren as part of the OSHC/Vac Care program and to be displayed around the OSHC site on display boards and in newsletters. ☐

I consent for an Educator to apply sunblock supplied for my child as required. ☐

I consent to my child viewing G & PG rated movies. ☐

I/we understand the school/OSHC have a behaviour management policy and I/we accept responsibility to support the process involved. ☐

I give permission for an OSHC Educator to check my child's hair for head lice and their eggs. I understand any such check will be conducted sensitively. I understand and accept that I will need to collect my child promptly if head lice or their eggs are evident. ☐

I/we agree to restrict our child's school lunch and recess food to eliminate nuts and nut products. ☐

I/we support the 'Sunsafe' policy when children are outdoors by supplying my child/ren with a bucket, wide-brimmed or legionnaires style hat from 1st September to 31st May each year. ☐

I consent for OSHC Eductors to exchange information relating to my child with school staff and to the appropriate person(s) (eg. In an emergency / special needs relative to my child/ren). ☐

I consent to my child participating in excursions as arranged by vacation care and understand that it is the parent's responsibility to make alternative arrangements of care for that day if I do not wish my children to participate in the Excursions ☐

BOOKING

Before School Care	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Full Session 6.30—8.30 am					

After School Care	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Full Session 3.05-6.30pm					

From: for: weeks / or until or ongoing (tick) ☐

AGREEMENT

I acknowledge that I have received a Family Handbook and agree to abide by the rules, policies and procedures of the service.

I agree to pay the required fees for my child's booked childcare sessions and any relevant additional charges including, but not limited to, late fees and incursion/excursion fees.

I agree to notify the Director of any change to information provided on the enrolment form.

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 Educators of the service consider that my child requires emergency medical/hospital/ambulance assistance, they will have the local medical/hospital/ambulance attend my child/ren. I acknowledge that I will be liable for any medical/hospital/ambulance expenses incurred in the treatment of my child/ren.

I understand that OSHC/Vac Care Educators require written permission for my child/ren to travel alone, to and from the OSHC service. I am aware that the Director/Qualified educator will sign my child/ren in and out of the service and the arrival and departure times will be noted.

I understand that it is my responsibility to ensure all Child Care Benefit requirements are fulfilled and if I fail to do so I will be responsible for paying full fees.

Signature of parent/guardian: Date:

CENSUS INFORMATION

Each year Out of School Hours Care services are required to provide State and Commonwealth authorities with a general overview of the children/ families utilizing the service. The information provided below will assist us in completing these censuses and will be kept confidential. Neither your name nor your child's name is included in the census reports.

Please tick the boxes below that apply to your child.	YES	NO
Is the child an Aboriginal or Torres Strait Islander? (please circle)	☐	☐
Is the child's parent/s born overseas in a country where English is not the first language?	☐	☐
Is English the main language spoken at home?	☐	☐
Do the child's parents have a continuing disability?	☐	☐
Does the child experience any of the following:		
Hearing Impairment	☐	☐
Visual Impairment	☐	☐
Physical Disability	☐	☐
Speech and Language Disorder	☐	☐
Developmental Delay (delayed development in 2 or more areas)	☐	☐
Health or Medical Condition (that requires continuing treatment eg. Asthma, epilepsy)	☐	☐
Intellectual Disability	☐	☐
Severe Multiple Disability	☐	☐
Attention Deficit Hyperactivity Disorder (ADHD)	☐	☐
Other (please specify)…….	☐	☐

PRIORITY OF ACCESS

Please indicate the priority that best describes your child's care requirements by ticking one of the following boxes

Priority 1— a child at risk of serious abuse or neglect ☐

Priority 2— a child of a single parent who is currently working/training/studying or a child of parents who both are currently working/training/studying ☐

Priority 3— any other child ☐

Please tick any boxes below that apply to your child's situation

Children in a family which includes a disabled person ☐

Children of single parents (individual who has no partner) ☐

Privacy Act

I understand the information provided on these forms is collected for the purpose of registration, program-planning, preparing of statistics, reporting and evaluation. The information may be disclosed to, and used for the purpose of, Commonwealth and State government departments and their agencies. The information may otherwise be disclosed without consent where authorised or required by law. I certify that the information entered upon these forms is true to the best of my knowledge and I undertake to inform the Service if any of these details change.

Signature of parent/guardian: _____ Date: _____

Interviewed/accepted by: _____ Date: _____