ST MEL'S
OUTSIDE SCHOOL HOURS CARE
SERVICE MOBILE: 0438213163
DIRECTOR: Veronica Bowman

ENROLMENT FORM – AFTER SCHOOL CARE SERVICE

DETAILS OF CHILD

First Name……

Preferred First Name ……

Surname……...

Male Female (please circle)

Date of Birth……

Languages spoken……Main language spoken……

Is your child of Aboriginal and/or Torres Strait Islander descent? YES NO (please circle)

Does either parent/guardian have a disability? YES NO (please circle)

School……..

Grade……Teacher……

1. DETAILS OF PARENT/GUARDIAN

Name……...

Address……...

……

Telephone (Home)……

(Work)……

(Mobile)……..

Email address……

Date of Birth……

Employer……

Occupation……

Languages spoken……

Does the child live with this parent/guardian?

YES/NO

2. DETAILS OF PARENT/GUARDIAN

Name……...

Address……...

……

Telephone (Home)……

(Work)……

(Mobile)……..

Email address……

Date of Birth……...

Employer……

Occupation……

Languages spoken……

Does the child live with this parent/guardian?

YES/NO

OTHER RESIDENCY ARRANGEMENTS

(Please give details) Telephone (Home)……

Name……... (Work)…….

Address……... (Mobile)……..

…….

CIRCLE THE DAYS YOUR CHILD WILL BE REQUIRING CARE:

PERMANENT BOOKINGS

AFTER SCHOOL CARE:

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

Start Date:

ACCOUNT DETAILS

Would you like to receive your invoice by email?
Yes/No

Invoice to be sent to:
(Please circle)

Parent/Guardian 1…….. Parent/Guardian 2…….

FEES

Have you applied for Child Care Benefit? YES NO (please circle)

(If yes, please provide relevant information)

(CRN = Customer Reference Number for Child Care Benefit)

Parent/Guardian 1 CRN:……..

Parent/Guardian 2 CRN:……..

Child CRN:……..

MEDICAL INFORMATION

Does your child have any special needs? YES NO

If yes please provide details of any special needs and any management procedure to be followed with respect to the special need.

.....

.....

How would you describe your child's health?.....

…

……

Is he/she under any medical treatment?.....……

……..

Has he/she had any history of illness? Please give details…….

…….

Allergies……

Medical Conditions…….

Medical Plan……

Other…….

Asthma

Asthma YES NO (please circle)

Asthma Medication/Treatment…….

Do you have an Asthma Plan? YES NO (please circle)

Are there any known triggers?.....

……..

Diabetes

Diabetes YES NO

Does your child have an auto injection device (e.g. Insulin) YES No (please circle)

Do you have a diabetes management plan? YES NO (please circle)

Has the diabetes management plan been provided to the service? YES NO

Has a risk management plan been completed by the service in consultation with you?

YES NO (please circle)

Anaphylaxis

Has your child been diagnosed at risk of anaphylaxis? YES NO (please circle)

Does your child have an auto injection device (eg EpiPen)? YES NO (please circle)

Has the anaphylaxis management plan been provided to the service? YES NO

Has a risk management plan been completed by the service in consultation with you?

YES NO (please circle)

In the case of anaphylaxis, asthma or diabetes you will be provided with a copy of the services medical conditions policy as well as the anaphylaxis management policy for anaphylaxis children. You will be required to provide the service with an individual plan for your child signed by the medical practitioner who is treating your child. This will be attached to your child's enrolment form. More information is available at www.education.vic.gov.au/anaphylaxis

Has your child been immunised? YES NO (please circle)

Please provide a copy of your child's immunisation record.

Does your child have a health record? YES NO (please circle)

***If yes,** please provide to the Director of the service for sighting.*

Child health record means a record that documents a child's health and development assessments and immunisations.

Name and position of person at the children's service (OSHC) who has sighted the child's health record.

Name: .....Position.....

Does your child have any dietary restrictions? YES NO

If yes, the following restrictions apply:.....

.....

FAMILY DOCTOR

Doctor's Name…….Phone……..

Name of Practice……

Address……

Medicare Number……

Do you have Private Medical Insurance? ……..

Do you subscribe to an Ambulance Service? YES NO (please circle)

If yes, please state the Ambulance Subscription Number and Category

……

OTHER INFORMATION

Is there any other information we should know about your child? Likes, dislikes, favourite activities, cultural information etc.

……..

…

……..

CUSTODY DETAILS

Are there special access/custody arrangements? YES NO (please circle)

If yes, please give details…….

…….

…….

If a court order exists please provide this information to the Coordinator.

1. Bring the original court order/s for staff to sight and a copy to attach to the enrolment form
2. If these orders;

   a. Change the powers of a parent/guardian to:

   - authorise the taking of the child outside the service by a staff member of the service
   - Consent to the medical treatment of the child
   - Request or permit the administration of medication to the child
   - Collect the child

AND/OR

   b. Give these powers to someone else,

Please describe these changes and provide the contact details of any person given these powers:……..

…….

AUTHORISED NOMINEES BY PARENTS/ GUARDIANS

Please tick the appropriate boxes for each contact to confirm authorisations

(In accordance with the Education and Care Services National Regulations *(Reg. 160(3(b)(ii)(iii)(iv)(v))*

In event that the child/children's parents or guardians cannot be contacted, please authorise nominees who can collect your child/children from our service, can be contacted in an emergency, and can give consent for medical treatment, administration of medication and can authorise an Educator to take your child/children outside the Service premises.

AUTHORISED NOMINEES (please indicate permissions below for each Nominee

- To collect your child from our Service
- In the event of an emergency involving your child when the parents/guardians are not available
- To give consent to medical treatment or the administration of medication and the parents/guardians are not available
- To authorise an Educator to take your children outside of the Service premises and the parents/guardians are not available

NOMINEE 1	**NOMINEE 2**
Name	Name
Address	Address
Home Phone	Home Phone
Mobile	Mobile
Work	Work
Relationship to child	Relationship to child
Authorisations	**Authorisations**
☐ To collect the child from the OSHC service	☐ To collect the child from the OSHC service
☐ To be notified in the event of an emergency	☐ To be notified in the event of an emergency
☐ Is authorised to consent to medical treatment	☐ Is authorised to consent to medical treatment
☐ Is able to authorise an Educator to take the child outside the OSHC service premises	☐ Is able to authorise an Educator to take the child outside the OSHC service premises

NOMINEE 3	**NOMINEE 4**
Name	Name
Address	Address
Home Phone	Home Phone
Mobile	Mobile
Work	Work
Relationship to child	Relationship to child
Authorisations	**Authorisations**
☐ To collect the child from the OSHC service	☐ To collect the child from the OSHC service
☐ To be notified in the event of an emergency	☐ To be notified in the event of an emergency
☐ Is able to authorise an Educator to take the child outside the OSHC service premises	☐ Is able to authorise an Educator to take the child outside the OSHC service premises
☐ Is authorised to consent to medical treatment	☐ Is authorised to consent to medical treatment

DECLARATION AND CONSENT TO EMERGENCY MEDICAL TREATMENT

I/We ……(Print full name/s)

Person/s with lawful authority of the child referred to in this enrolment form,

- Declare that the information in this enrolment form is true and correct and undertake to immediately inform the OSHC service in the event of any change to this information

- Agree to collect or make arrangement for the collection of the child referred to in this enrolment form if he/she becomes unwell at the service

- Consent to the staff of the OSHC service seeking medical treatment by a medical practitioner, hospital or ambulance service, or where appropriate, administer such emergency medical treatment as is reasonably necessary and agree to reimburse any necessary expenses incurred by the OSHC service

- Undertake to inform the staff of any absence of my child from the service

- Accept full responsibility for my child's belongings whilst attending the service

PHOTOGRAPHIC CONSENT

I give permission for my child to be photographed by staff members; I understand that these photos are for the service use only and may be used for promotional material for the service.

YES NO (Please circle)

I give permission for my child to be photographed and/or video taped in the event of media reportage.

YES NO (Please circle)

SUNSCREEN CONSENT

I give permission for my child to have a 30+ sunscreen applied as per the service's Sun Smart Policy.

YES NO (Please circle)

POLICY AND PHILOSOPHY STATEMENT

I agree to abide by all policy and philosophy guidelines of the service.

YES NO (Please circle)

PARENT/GUARDIAN SIGNATURE/S

……

……

DATE ……

PRIVACY NOTIFICATION

The (Service Name) uses the enrolment form to collect personal information for the purposes of service enrolment and statistical recording. The information may be shared with funding agencies and administrators for operational purposes only. The information will not be disclosed to any other party except as required by law. You are able to amend or correct information on request, by contacting the service coordinator.