

# ORRVALE PS OUTSIDE SCHOOL HOURS CARE

**2021 ENROLMENT FORM**

# Student Details - Personal Details of Student/s

Child/ren’s Surname ……………………………………………….

First Child’s (Oldest) Name …………………… Gender …………… DOB ……...…… Grade ……………….

Second Child’s Name ……..………..……… Gender ……..……… DOB …..…...…… Grade ……..……..….

Third Child’s Name ………..……..………… Gender ………..…… DOB …….....…… Grade ……..………...

First Child’s Name ……………….………… Gender …………...… DOB ……….…… Grade …….………….

School …………………………………

Aboriginal/Torres Strait Islander Yes/No Cultural Background………………………………...........

Primary Language Used at Home:

□ English

□ Other—Please Specify………………………………………………….

Any cultural, religious, dietary requirements or additional needs: Yes/No \* If answered yes, please list details:

………………………………………………………………………………………………………………………………………

1. **ENROLLING PARENT/GUARDIAN & BILLING DETAILS (person responsible for bills & CCB)**

Name …………………………………………………………………………………. DOB……………………..

Relationship to child/ren…………………………………………….. Contact Priority …………………………

Billing Address ………………………………………………………………………………………………………

Home Phone ………………………………...……… Mobile ………………………………………..….……….

Work Phone ………………………………………… Email ……………………………………………………..

**OTHER PARENT/GUARDIAN (if applicable)**

Name …………………………………………………………………………………. DOB……………………..

Relationship to child/ren…………………………………………….. Contact Priority …………………………

Home Address ………………………………………………………………………………………………………

Home Phone ………………………………...……… Mobile ………………………………………..….……….

Work Phone ………………………………………… Email ……………………………………………………..

## 3. Family Emergency Contacts & authorised person

## to collect children:

(Maximum of 30 minutes from school)

In case of accident or injury, trauma or illness when parents/guardians are not available, the persons below will be contacted to pick up the child and take care of them. In the event that the child is not collected from the children’s service and the parent or guardians cannot be contacted, this list will also be used to arrange someone to collect the child. To consent to medical treatment of, or to authorise administration of medication to the child, and authorise an educator to take the child outside the education and care service.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Name | Relationship | Telephone Contact | Language Spoken |
|  |  | (Neighbour, Relative, Friend or Other) |  | (If English Write “E”) |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |

## 4. Custody Details

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

If ‘YES’ please provide details, including a copy of any Court Orders pertaining to the child.

#### 5. ARRIVAL & PICK UP PROCEDURES (Circle response)

#### I/we are aware of the Policy of my /our children/ren’s arrival and departure from the service. Yes No

#### I/we agree to sign out my/our child/ren when leaving the service. Yes No

#### 

#### Signature ........................................................................ Date …….……………

## 6. Student Medical Details

### Medical Condition Details:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Does the student suffer from any of the following impairments? (tick) | Hearing: | 🞎 Yes | 🞎 No | Vision | | 🞎 Yes | 🞎 No |
| Speech: | 🞎 Yes | 🞎 No | Mobility: | | 🞎 Yes | 🞎 No |
| Does the student suffer from Asthma? (tick) If No, please go to the Other Medical Conditions section | | | | | 🞎 Yes | | 🞎 No |

### Asthma Medical Condition Details:

Answer the following questions ONLY if the student suffers from any asthma medical conditions.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please indicate if the student suffers from any of the following symptoms: (tick) | | | | | | | | | If my child displays any of these symptoms please: (tick) | | | | | | | | | | | | | |
| 🞎 Cough | | | | | | | | | Inform Doctor | | | | | | | | | | 🞎 Yes | | | 🞎 No |
| 🞎 Difficulty Breathing | | | | | | | | | Inform Emergency Contact | | | | | | | | | | 🞎 Yes | | | 🞎 No |
| 🞎 Wheeze | | | | | | | | | Administer Medication | | | | | | | | | | 🞎 Yes | | | 🞎 No |
| 🞎 Exhibits symptoms after exertion | | | | | | | | | Other Medical Action | | | | | | | | | | 🞎 Yes | | | 🞎 No |
| 🞎 Tight Chest | | | | | | | | | If yes, please specify: | | | | | | | | | |  | | | |
| Has an Asthma Management Plan been provided to School? | | | | | | | | | | | | | | | | | | | 🞎 Yes | | | 🞎 No |
| Does the student take medication? (tick) | | | | | 🞎 Yes | 🞎 No | | | | Name of medication taken: | | | | | | |  | | | | | |
| Is the medication taken regularly by the student (preventive) or only in response to symptoms? (tick) | | | | | | | | | | | | | | 🞎 Preventative | | | | | | | 🞎 Response | |
| Indicate the usual dosage of medication taken: | | |  | | | | | | | Indicate how frequently the medication is taken: | | | | | |  | | | | | | |
| Medication is usually administered by: (tick) | | | | | | 🞎 Student | | | | | | 🞎 Nurse | | | 🞎 Teacher | | | | | 🞎 Other | | |
| Medication is stored: (tick) | | | | 🞎 with Student | | | | 🞎 with Nurse | | | | | 🞎 Fridge in Staff Room | | | | | | | 🞎 Elsewhere | | |
| Dosage time |  | Reminder required? (tick) | | | | | 🞎 Yes | | | | 🞎 No | | Poison Rating | | | | |  | | | | |

### Other Medical Conditions

(More copies of the other medical condition forms are available on request from the school.)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Does the student have any other medical condition? (tick) | | | | | | | | | | | | | | | | | | | | 🞎 Yes | 🞎 No |
| If yes, please specify: |  | | | | | | | | | | | | | | | | | | | | |
| Symptoms: |  | | | | | | | | | | | | | | | | | | | | |
| If my child displays any of the symptoms above please: (tick) | | | | | | | | | | | | | | | | | | | | | |
| Inform Doctor | | | | 🞎 Yes | | 🞎 No | | | | Inform Emergency Contact | | | | | | | | | 🞎 Yes | | 🞎 No |
| Administer Medication | | | | 🞎 Yes | | 🞎 No | | | | Other Medical Action | | | | | | | | | 🞎 Yes | | 🞎 No |
|  | | | | | | | | | | If yes, please specify: | | | | |  | | | | | | |
| Does the student take medication? (tick) | | | | | 🞎 Yes | | 🞎 No | | | Name of medication taken: | | | | | |  | | | | | |
| Is the medication taken regularly by the student (preventive) or only in response to symptoms? (tick) | | | | | | | | | | | | | 🞎 Preventative | | | | | | | 🞎 Response | |
| Indicate the usual dosage of medication taken: | | |  | | | | | | | Indicate how frequently the medication is taken: | | | | | | | | | |  | |
| Medication is usually administered by: (tick) | | | | | | | | 🞎 Student | | | 🞎 Nurse | | | 🞎Teacher | | | 🞎 Other | | | | |
| Medication is stored: (tick) | | 🞎 with Student | | | | | | | 🞎with Nurse | | | 🞎 Fridge | | | | | | 🞎 Elsewhere | | | | |
| Dosage time | | Reminder required? | | | | | | | Y/N | | | Poison Rating | | | | | |  | | | | |
| Office Use Only | | Health record sighted? | | | | | | | Y/N | | |  | | | | | |  | | | | |

## Student Doctor Details

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Doctor’s Name: |  | | | |
| Individual or Group Practice: (tick) | | | 🞎 Individual | 🞎 Group |
| No. & Street or PO Box No.: |  | | | |
| Suburb: |  | | | |
| State: |  | Postcode: |  | |
| Telephone Number |  | Fax Number |  | |
| Student Medicare Number: |  | | | |

#### Any other medical information we need to know

#### …………………………………………………………………………….……………………………………………..

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**7. Fees & Bookings**

Session of Care:

***Permanent $17.00 per child per session***

***Casual $18.00 per child per session***

Late Pick Up $5.00 per 15 minutes per child will apply if children are not collected by 6:00pm.

**Permanent Booking** – is an ongoing position kept available in the program and must be paid for EVEN if the child is absent, on holidays or away during the school term. If you are to cancel a permanent booking, 1 week’s notice must be given.

**Casual Bookings** – are for positions made available on a daily basis and are subject to availability. Casual bookings need to be made to the office before 2:00pm on the day and also cancellations need to be made by this time otherwise the fee may still be charged.

Care can be used any time between the hours of 3.20-6.00pm. Please circle the type of booking you wish to have for your child/ren:

If requesting a permanent booking, please indicate which days are required below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Monday | Tuesday | Wednesday | Thursday | Friday |
|  |  |  |  |  |

Have you applied for a Child Care Subsidy? (Please circle) YES NO

If ‘YES’, please ensure you have provided the relevant CRN information below. Please note, unless you provide this information, we will not be able to claim the rebate on your behalf which means you will have to pay full cost of care (no Centrelink reduction).

PARENT CRN NO………………………………………………………... PARENT DOB………………………………………..

ALL CRN’S must be filled out:

CHILD 1 CRN NO……………………….……… Gender………....….DOB …..………. Name …….………………..………….

CHILD 2 CRN NO……………………….……… Gender………....….DOB …..………. Name …….………………..………….

CHILD 3 CRN NO……………………….……… Gender………....….DOB …..………. Name …….………………..………….

CHILD 4 CRN NO……………………….……… Gender………....….DOB …..………. Name …….………………..………….

**8. Permission to Use**

I give permission for my child to be photographed by staff members and have these photos displayed in the program.

YES NO (please circle appropriate response)

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

YES NO (please circle appropriate response)

I give permission for my child to have sunscreen applied as per the centre’s Sunsmart Policy

YES NO (please circle appropriate response)

I give permission for my child to watch PG rated movies

YES NO (please circle appropriate response)

**9. Declaration**

I/We \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print full name/s) as 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 children’s service in the event of any change to this information.
* Understand that all Enrolment details are private and confidential. This information will be used for Program purposes only and will be accessible to OSHC staff, Committee of Management, the Principal and/or the Sponsoring body. I understand that I can access this information and correct any necessary details whenever I wish.
* Approve of the enrolment and agree to abide by the rules and conditions of the Outside School Hours program and meet any costs incurred.
* Acknowledge that my child will not attend the program if suffering from an infectious or contagious disease. I/we 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 children’s 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 children’s service.
* Accept full responsibility for my child’s belongings whilst attending this program. I fully understand that if my child continuously misbehaves and after behaviour guidance procedures have been followed, I will be notified and my child may be removed from the program.
* Undertake to inform the staff of any absence of my child.

**PRIVACY NOTIFICATION**

Orrvale Primary School Outside School Hours Care program uses the enrolment form to collect personal information for the purposes of program 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 Program Coordinator.

I certify that the information contained within this form is correct.

Signature of Parent/Guardian: Date: \_\_\_\_\_ / \_\_\_\_\_ /\_\_\_\_\_