BLACKFRIARS
PRIORY SCHOOL

BLACKFRIARS PRIORY SCHOOL: OSHC & VACATION CARE
ENROLMENT FORM – 2016

CHILD

Family Name:_____ First Name: _____
DOB:_____ M/F Teacher/Year: _____
CRN Number (if eligible): _____ School: _____
_____ Torres Strait Islander YES / NO
Indigenous Status: Aboriginal YES / NO

ENROLLING PARENT/GUARDIAN AND BILLING DETAILS

Family Name: _____ Occupation: _____
First Name: _____ Work Address: _____
Relationship: _____ Work Telephone:_____
Address: _____ _____
_____ Mobile Telephone: _____
Email Address: _____ Home Telephone: _____
CRN Number (if eligible):_____ Contact Priority:_____
_____ _____
D.O.B. (for CRN): _____

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 DETAILS

Name: _____ Occupation: _____
Relationship: _____ Work Address: _____
Address: _____ Work Telephone:_____
_____ _____
Home Telephone: _____ Mobile Telephone: _____
Contact Priority:_____
_____

EMERGENCY CONTACT DETAILS

PLEASE NOTE: 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.

Name: _____ Name: _____
Relationship: _____ Relationship: _____
Home Telephone: _____ Home Telephone: _____
Work Telephone:_____ Work Telephone:_____
_____ _____
Mobile Telephone: _____ Mobile Telephone: _____
Contact Priority:_____ Contact Priority:_____
_____ _____

COLLECTION AUTHORITIES ONLY

PLEASE NOTE: The people nominated here have been given approval only to collect the child and will NOT be contacted in the event of an emergency.

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Home Telephone: _____	Home Telephone: _____
Work Telephone:_____	Work Telephone:_____
_____	_____
Mobile Telephone: _____	Mobile Telephone: _____
Contact Priority:_____	Contact Priority:_____
_____	_____

MEDICAL AND HEALTH INFORMATION

Does your child need special aids or equipment? (eg. glasses, hearing aid, callipers). If YES please provide the details:_____

_____

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

If no, please provide details:_____

I accept full responsibility if my child is not immunised. Signature:_____

_____

Has your child any conditions / medications that may be affected by OSHC activities? If yes, please give specifics and any related medication:_____

_____

_____

Does the child have any disabilities? YES / NO Effective date: _ _/_ _/_ _ _ _

If yes, please record specifics: :_____

_____

Does the child have any special needs? YES / NO Effective date: _ _/_ _/_ _ _ _

If yes, please record specifics:

_____

_____

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? If yes, please give details:

Usual Medical attendant	Usual Dental attendant
Doctor's name:	Dentist's name:
Clinic name:	Clinic name:
Phone No:	Phone No:
Address:	Address:

All medication must be suppled in the original container with the child's name clearly marked on the container. A permission to administer medication form must be signed by the parent before medication can be administered by OSHC staff. If medication to be supplied is due to an ongoing medical illness then an action plan must be provided by your child's Doctor.

Signed: _____ Date: _____

CUSTODY (to be completed if custody is an issue for the family)

Are parents separated or divorced?

YES/NO

Do the children have contact with the non-custodial parent?

YES/NO

Is anyone legally denied access to the child/children?

YES/NO

Who?_____ Custody Number: _____

Is there additional information regarding separation or custody that OSHC staff may need to know?

_____

RELIGIOUS AND CULTURAL PREFERENCES

Religion: _____ Parents Country of Birth – Mother: _____

Father: _____

Please describe any child/family preferences or further information that OSHC staff should be aware of (i.e. cultural, religious etc).

_____

CONFIDENTIAL GOVERNMENT INFORMATION

Various Government services require this information. Please circle the appropriate number. This information remains confidential.

Reason for Attendance	Special needs
01 Single Parent studying 02 Single parent working 03 Both parents studying 04 Both parents working 05 One parent working/one studying 06 Respite purposes 07 At risk/referral 08 Parent disability 09 Child disability	01 Hearing Impairment 02 Visual Impairment 03 Physical Disability 04 Speech and Language 05 Emotional/Behaviour 06 Special Family Needs 07 Gifted 08 Geographic Location 09 Health/Medical Condition 10 Intellectual Disability 11 Special Diet 12 Severe Multiple Disability 13 ADHD Attention Deficit Hyperactivity Disorder 14 Other

AMBULANCE COVER

After attempts have been made to notify parents/guardians/emergency contacts in the event of an emergency situation, I _____ authorise OSHC Staff to seek medical, hospital and/or ambulance services for my child/children. I understand that medical records/relevant information relating to my child will accompany him/her. I give permission for an exchange of information to the appropriate person/s. I understand that this information will be treated confidentially.

Signed: _____ Date: _____

Children enrolled at Blackfriars Priory School are covered for Ambulance Service at Before School, After School, Pupil Free days and Vacation Care.

Legal responsibility for paying Ambulance Service fees for children not enrolled in Blackfriars Priory School rest with the parent or guardian of the child. The Ambulance Service will render an account in the name of the parent/guardian concerned. This is in accordance with the requirements of the Ambulance Services Act 1992. If the parent or guardian is not a member of the ambulance service but has some form of insurance which covers ambulance services then the parent/guardian must submit the account to that insurer for payment.

I/We on behalf of the child/ren named on this form have ambulance insurance cover with:
St John Ambulance YES / NO
Any other insurer details _____

_____

Is the child is covered by a private medical benefits fund as well as Medicare? YES / NO
Medicare Number:_____ Medicare Expiry Date:_____
Private Health Insurance Fund: _____ Contribution Number: _____

IMPORTANT INFORMATION

Is there any anything more we need to know? (eg. Comments on homework, behaviour management)

_____

_____

_____

_____

_____

BOOKINGS

I require a casual booking for OSHC YES / NO

I require a permanent booking for OSHC YES / NO

If you require a permanent booking, please complete the following section and tick the box which applies to your care requirements:

BSC	Monday	Tuesday	Wednesday	Thursday	Friday
Arrive					
Depart					

ASC	Monday	Tuesday	Wednesday	Thursday	Friday
Arrive					
Depart					

VAC	Monday	Tuesday	Wednesday	Thursday	Friday
Arrive					
Depart					

CONSENTS

I give my permission for

- My child/children to participate in supervised walks/visits to the local shop etc as part of the OSHC program. YES/ NO
- OSHC staff to apply sun block to my child if required. YES/ NO
- OSHC staff to exchange information relating to my child/children with school staff and appropriate persons (i.e. in an emergency situation – special needs for my child/children). I understand that this information will be handled confidentially. YES/ NO
- I consent for my child to be photographed and for their image, name and work to be published in OSHC letters, booklets and newsletters. YES/ NO
- My child/children to wear no shoes inside if the weather is hot. YES/ NO

AGREEMENTS

- I have read the OSHC information package and am aware of and agree to comply with the services, policies and procedures as outlined. YES/ NO
- In an emergency if I am unable to be contacted I give permission for medication to be administered to my child/children. I understand that this will only be after permission is received from a Medical Practitioner. YES/ NO
- I understand the information provided on this Enrolment Form is collected for the purpose of registration, planning, reporting and evaluating; that the information may be disclosed to and used for the purposes by Commonwealth and State government departments and their agencies; and may otherwise be disclosed without consent where required by law. YES/ NO

Enrolling Parent/Guardian Signature:_____ Date:_____

I agree to pay the required fees for my child/children's care. I certify that the information on these forms are true to the best of my knowledge and I undertake to inform the OSHC Director if any details change.

Signed: _____ Date:_____