Coburg West Primary School
Out of School Hours Childcare Program

Enrolment Form

This document will be reviewed 3 years from the date of issue/review.

Please complete all sections of this form using **BLOCK LETTERS**. The information provided MUST be the same as what is provided to centrelink. Enrolment Date: _____

Section 1: Child's Details

Child's: _____ _____ _____
First Name *Middle Name* *Surname*

Date of birth: _____ **Gender:** ☐ **Male** ☐ **Female**

Address: _____

Parent / Caregiver Email: _____

CRN No. _____ **Child's Grade Level** _____

Child's: _____ _____ _____
Birth Country *Language spoken at home* *Religion*

Is this child of Aboriginal or Torres Strait Islander decent? ☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **No**

Section 2: Child's Medical Details

Family Doctor: _____ _____ _____
Name *Address* *Contact Number*

Medicare Number _____

Ambulance Subscription: ☐ **Yes** ☐ **No** **(If yes, provide subscription No.)** _____

Private Health Insurance ☐ **Yes** ☐ **No** **Fund Name:** _____

Membership Number: _____

Does this child have any allergies or sensitivities? ☐ **Yes** ☐ **No**
(If Yes please specify by ticking the boxes below)

Does this child have Anaphylaxis? **Yes** ☐ **No** ☐ ☐ **Action plan attached**
Does this child have Asthma? **Yes** ☐ **No** ☐ ☐ **Action plan attached**

Does this child have any other medical conditions or needs? ☐ **Yes** ☐ **No (If Yes please specify)**

Does this child have a developmental delay or disability including intellectual, sensory or physical impairment? ☐ **Yes** ☐ **No (If Yes please specify)**

_____

Please specify if your child has any dietry restrictions eg: (cultural/religious). _____

IMPORTANT!: IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE PROVIDE A PHOTO OF YOUR CHILD AND ANY RELEVANT DOCUMENTATION.

Section 3: Immunisation Details

Has this child been immunised? ☐ Yes ☐ No

PLEASE NOTE: **(If Yes provide copy of immunisation certificate)** ☐ Attached

Section 4: Other Details

Is there any other relevant information that the staff need to be aware of when caring for your child? i.e fears, concerns

Section 5: Parent / Caregiver Details (This is the Parent who is registered with Centrelink for Childcare benefit)

Parent / Caregiver: _____ _____
First Name *Surname*

Address: _____ **Post code:** _____

Parent / Caregiver Email: _____

Contact Numbers: _____ _____ _____
Home **Mobile** **Work**

Parent / Caregiver: _____ _____ _____
Birth Country *Language spoken at home* *Religion*

Date of birth: _____ **Gender:** ☐ Male ☐ Female

_____ _____
Occupation *Place of Employment*

Address of Employment: _____ **Post code:** _____

Parent / Caregiver CRN No. _____

Do you require help reading English? (in relation to the program) ☐ Yes ☐ No

Section 6: Parent / Caregiver Details

Parent / Caregiver: _____ _____
First Name *Surname*

Address: _____ **Post code:** _____

Parent / Caregiver Email: _____

Contact Numbers: _____ _____ _____
Home **Mobile** **Work**

Parent / Caregiver: _____ _____ _____
Birth Country *Language spoken at home* *Religion*

Date of birth: _____ **Gender:** ☐ Male ☐ Female

_____ _____
Occupation *Place of Employment*

Address of Employment: **Post code:**

Section 7: Court Orders Relating to Child

Are there any Court Orders relating to the powers and responsibilities of the parent / caregiver in relation to the child or access to the child?

☐ **Yes** ☐ **No**

(If Yes provide copy of Court Order) ☐ **Attached**
Original MUST be sighted.

Section 8: Siblings in other care where Childcare Benefit is received from Centrelink

Child's: _____ _____ _____
Name **Date of Birth** **CRN**

Centre: _____

Child's: _____ _____ _____
Name **Date of Birth** **CRN**

Centre:

Section 9: Reason for requiring care

Priority of access:

☐ **First Priority:** A child at risk of serious abuse or neglect

☐ **Second Priority:** A child of a single parent who satisfies or of parents who both satisfy the Work / Training / Study Test under Section 14 of the Family Assistance Act. Second priority also goes to siblings of current users.

☐ **Third Priority:** Children of families with other commitments (familiy, social etc.)

☐ **Fourth Priority:** Any other child

Will you be registering with Centrelink? ☐ **Yes** ☐ **No** **Service Provider Code: 555 010 650L**

Section 10: Usage Requirements

	Before Care	**After Care**
What type of booking is required?	☐ **Permanent** ☐ **Casual**	☐ **Permanent** ☐ **Casual**
Which days are required?	☐ **Monday**	☐ **Monday**
	☐ **Tuesday**	☐ **Tuesday**
	☐ **Wednesday**	☐ **Wednesday**
	☐ **Thursday**	☐ **Thursday**
	☐ **Friday**	☐ **Friday**

Section 11: Emergency Contacts (Exclude parents / caregivers from this list)

Emergency contacts are people who are nominated to collect your child/ren from the program on your behalf. Emergency contacts need to be people who live within a 30 minute drive or closer to the school.

	First Contact	Second Contact	Third Contact
Relationship to child			
Name			
Address			
Home Phone			
Mobile			
Work Phone No.			
Work Address			

In case of an accident or injury being sustained by my child, I authorise the relevant emergency contacts above, where it is Impracticable to communicate with me, to arrange emergency medical, surgical treatment or administration of medicine as may be deemed necessary. Including transportation of my child to hospital by ambulance. I accept that I will be responsible for any costs incurred.

SIGNATURE _____ DATE_____

Section 12: Declaration and Consent to Emergency Medical Treatment

I, …… (Please print full name), the authorized Parent or Caregiver of the child named on this **Enrolment Form**.

- Declare that the information in this **Enrolment Form** is true and correct and I will immediately notify the Out of School Hours program of any changes to this information;
- Agree to collect or make arrangements for the collection of my child referred to in this **Enrolment Form** if he / she becomes unwell;
- In case of an accident or injury being sustained by my child, I authorise the relevant Program Co-ordinator or Delegate of the Out of School Hours Childcare Program, where it is impracticable to communicate with me, to arrange emergency medical or anaesthetics, blood transfusions and surgical treatments or operations as may be deemed necessary. Including the transportation of my child to hospital by ambulance. I accept that I will be responsible for any costs incurred.

Parent / Caregiver _____ _____
Signature **Date**

Witness (Program co-ordinator) _____ _____
Signature **Date**

Section 13: General Permission

Please tick to acknowledge your permission for the following:

- ☐ For the Program to display information regarding your child, within the Program only. This information will only be used to assist the Program staff with the care of your child in relation to Allergies, Special Needs Etc.

Parent / Caregiver _____ _____
Signature **Date**

Section 14: Cultural / Religious (This section is optional)

To assist the staff in the Program to help the children celebrate diversity in our community we are asking if there are any Cultural / Religious Festivals or Celebrations that you would like us to share with your child. Please provide us with the information regarding any special foods and recipes relevant to these celebrations.

Section 15.1: Movie Permission

I give permission for my child to watch G rated movies only **(please circle)** **Yes** or **No**

I give permission for my child to watch PG rated movies **(please circle)** **Yes** or **No**

I give permission for my child to access the internet and follow a Code of Practice, monitored by staff (***10 minute limit on all devices***). **(please circle)** **Yes** or **No**

Section 15.2: Photographs

During the year staff take photographs of the children participating in various activities. The photos taken are either placed on display in the OSHC Program or may be viewed on the program's digital photo frame.

I give permission for staff to photograph my child for the purposes stated above **Yes** or **No**

Section 15.3: Professional Photographs

During the year promotional (Newsletters, Newspapers) may take photographs of the children participating in various activities. The photos taken will include the display of the child's name.

I give permission for staff to photograph my child for the purposes stated above **Yes** or **No**

Section 15.4: Children's Art Work

Children's art work is displayed within the OSHC Program.

I give permission for my child's art work to be displayed **Yes** or **No**

I give permission for my child's name to be visible on their art work **Yes** or **No**

Section 15.5 Photos/Video taken by parents

During the year at special events and end of the year social concerts parents may take photos/video of the children participating in various activities. The photos/video taken will be for private use. The OSHC program will have no control over the use of the photos/video taken by other families and friends.

I give permission for my child to be included in photos/videos for the purposes stated above. **Yes** or **No**

I

Section 15.6 Birthday's

I give permission for my child's name and birth date to be displayed on the OSHC program Birthday calendar. **Yes** or **No**

Section:16 Privacy Statement

The Coburg West Out of School Hours Program 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.

Section 15.7 SUNSCREEN/BAND AIDS

I give permission for the Out of School Care Program to apply SPF (Anti-Cancer Council Sunscreen) to my child. **Yes** or **No**

I give permission for the Out of School Care Program to apply a Band Aid (Coles Medistrips latex free) to my child. **Yes** or **No**

Section 15.8 Parent/Caregiver Consent

I give permission for the program to take action as indicated above.

Name of Parent/Caregiver: _____ _____

First Name **Surname**

_____ _____

Signature **Date**

Updated June 2016