Craigburn OSHC

Enrolment Form 2017

Section 1

Child 1

Family Name:_____ Gender: F / M

First Name:_____ Known as: _____

Date of Birth:_____ CRN: _____

Allergy/ Medical conditions:_____

_____

_____

Child 2

Family Name:_____ Gender: F / M

First Name:_____ Known as: _____

Date of Birth:_____ CRN: _____

Allergy/ Medical conditions:_____

_____

_____

Child 3

Family Name:_____ Gender: F / M

First Name:_____ Known as: _____

Date of Birth:_____ CRN: _____

Allergy/ Medical conditions:_____

_____

_____

Child 4

Family Name:_____ Gender: F / M

First Name:_____ Known as: _____

Date of Birth:_____ CRN: _____

Allergy/ Medical conditions:_____

_____

_____

Enrolling Parent/Guardian & Billing details

Name:_____

Date of Birth:_____ CRN:_____

Relationship to child:_____ Contact Priority:_____

Address (h):_____

Phone: (h)_____ (w)_____ (m)_____

Email:_____

Other Parent/Guardian

Name:_____

Relationship to child:_____ Contact Priority:_____

Address (h):_____

Phone: (h)_____ (w)_____ (m)_____

Billing Details- if requesting second account

Date of Birth:_____ CRN: _____

Email:_____

Parenting Plans/Custody orders

_____

_____

_____

In Care Elsewhere

I am claiming Childcare Benefit at other Approved Childcare Service/s

Which includes LDC, OSHC, FDC, IHC, OCC for this number of children:_____

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Section 2

Emergency Contacts & Collection Authorities- in addition to parents/guardians

In nominating these people you give them authority to act on the child/rens behalf if neither parent/guardian can be located.

Person 1

Name:_____

Relationship to child:_____ Contact Priority:_____

Address (h):_____

Phone: (h)_____ (w)_____ (m)_____

Person 2

Name:_____

Relationship to child:_____ Contact Priority:_____

Address (h):_____

Phone: (h)_____ (w)_____ (m)_____

Collection Authorities only in addition to parents/guardians/emergency contacts

Person 1

Name:_____Relationship to child:_____

Phone: (h)_____ (w)_____ (m)_____

Person 2

Name:_____ Relationship to child:_____

Phone: (h)_____ (w)_____ (m)_____

Usual General practitioner

Doctor's name:_____ Phone no:_____

Clinic name:_____

Usual Dentist

Doctor's name:_____ Phone no:_____

Clinic name:_____

Private Health Insurance:_____Ambulance Cover with:_____

Medicare number:_____

Health Care Card Number: _____

Has your child/ren received all immunisations appropriate for their age? Yes / No

If no please give details:_____

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

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

Has the child/ren have any additional / special needs?

If yes, please give specifics and any related medication: (eg:Asthma-ventolin)

Has the child/ren have any special dietary requirements not related to allergies?

If yes, please give specifics:_____

Does the child/ren require special aids? (eg. Glasses, hearing aids)

If yes, please give specifics:_____

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

If yes, please give specifics:_____

Note: 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.

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Section 3

Bookings:

Please tick your booking requirements

Permanent: ☐ **Casual:** ☐

If you require a permanent booking please tick days and sessions required

From ___/____ / _____

	Monday	Tuesday	Wednesday	Thursday	Friday
BSC					
ASC					

Is there anything more we need to know?

Eg. Any personal, religious or cultural practices/prohibitions. Comments on homework or behaviour management.

Consents:

I consent for the Director to collect and share detailed health and wellbeing information with the school and to keep it on file as required. ☐

I consent for my child/ren to take part in supervised walking excursions within the local area as part of the services program. ☐

I consent for my child to be photographed and for their image and first name to be published in circumstance the Director deems appropriate. ☐

I consent for OSHC staff to apply sunscreen to my child if required. ☐

Agreement:

I agree to pay the required fees for my child/ren's booked childcare hours and accept the policies and rules of Craigburn OSHC.

I agree the OSHC staff may administer simple first aid to my child/ren if the need arises.

I understand that if at any time the OSHC staff considers that my child/ren 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.

I certify that the information entered upon this form is true to the best of my knowledge and I undertake to inform OSHC if any of these details change.

Parent/Guardian signature:_____ **Date:**_____

Interviewed by:_____ Signature:_____

Date:_____