

**Craigburn OSHC
Enrolment Form 2016**

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: _____

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: _____