OUTSIDE SCHOOL HOURS CARE PROGRAM
APPLICATION FOR ENROLMENT
2015

Before School Care: 6.45 – 8.45am
After School Care: 3.30 – 6.15pm

Contact: Joy Saunders - 0437 983 561

PRIVACY STATEMENT

The personal & health information requested on this form is being collected for administration purposes and to provide an informed duty of care to your child. The health information collected will be used solely by school council in providing its duty of care or for a directly related purpose. Where you seek a subsidy from the Family Assistance Office, your payment details will be disclosed to that body. If this information is not collected, it may prevent us from providing accurate information in the case of an emergency, or from providing our service to you. You can gain access to your personal health by the state government FOI website [http://www.foi.vic.gov.au].
# OUTSIDE SCHOOL HOURS CARE PROGRAM

## ENROLMENT FORM

### Information about the child's parents or guardians:

<table>
<thead>
<tr>
<th>Parent/Guardian 1</th>
<th>Parent/Guardian 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td>First Name:</td>
</tr>
<tr>
<td>Surname:</td>
<td>Surname:</td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Date of birth:</td>
</tr>
<tr>
<td>CRN:</td>
<td>CRN:</td>
</tr>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>Email address:</td>
<td>Email address:</td>
</tr>
<tr>
<td>Telephone: (H)</td>
<td>Telephone: (H)</td>
</tr>
<tr>
<td>Mobile:</td>
<td>Mobile:</td>
</tr>
<tr>
<td>Workplace:</td>
<td>Workplace:</td>
</tr>
<tr>
<td>Work Phone:</td>
<td>Work Phone:</td>
</tr>
<tr>
<td>Occupation:</td>
<td>Occupation:</td>
</tr>
</tbody>
</table>

**Does the child live with this guardian?**

- Yes ☐
- No ☐

*(please tick)*

**Language spoken at home:**

**Country of Birth:**

<table>
<thead>
<tr>
<th>Medicare no:</th>
<th>Medicare no:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Card no:</td>
<td>Health Care Card no:</td>
</tr>
<tr>
<td>Ambulance no:</td>
<td>Ambulance no:</td>
</tr>
</tbody>
</table>

### Name of Parent/Guardian registered to claim CCB.

Please call Centrelink on 13 61 50 if you haven't linked your CCB/CCR to the program.

### Child's Information.

**Family Name:**

**Date of Birth:**

**Sex:**

- M ☐
- F ☐

*(please tick)*

**Given Name:**

**Usually called:**

**Address:**

**Child's CRN:**

**Language spoken in the home:**

**Cultural background of the child if applicable:**

*Is the child of Aboriginal and/or Torres Strait Islander origin? (please circle)*

- No, not Aboriginal or Torres Strait Islander ☐
- Yes, Aboriginal ☐
- Yes, Aboriginal and Torres Strait Islander ☐

### Child's Health Information:

**Name Doctor/Medical Service:**

**Telephone:**

**Address Doctor/Medical Service:**

**Medicare No:**
Emergency Contacts:

You must nominate TWO emergency contacts over the age of 18 years (other than the parents/guardians) to be contacted in the case of an emergency.

I ____________________________(parent/guardian ) authorise the following people to:

<table>
<thead>
<tr>
<th>Emergency Contact 1</th>
<th>Emergency Contact 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collect my child from the program</td>
<td>Collect my child from the program</td>
</tr>
<tr>
<td>Please sign</td>
<td>Please sign</td>
</tr>
<tr>
<td>Authorise the service/staff to take my child outside the venue</td>
<td>Authorise the service/staff to take my child outside the venue</td>
</tr>
<tr>
<td>Please sign</td>
<td>Please sign</td>
</tr>
<tr>
<td>Authorise to give consent to the child receiving emergency medical treatment from a registered medical practitioner, hospital or ambulance service. Transportation by ambulance service if required.</td>
<td>Authorise to give consent to the child receiving emergency medical treatment from a registered medical practitioner, hospital or ambulance service. Transportation by ambulance service if required.</td>
</tr>
<tr>
<td>Please sign</td>
<td>Please sign</td>
</tr>
<tr>
<td>Request or permit to the administration of medication to my child by the service staff</td>
<td>Request or permit to the administration of medication to my child by the service staff</td>
</tr>
<tr>
<td>Please sign</td>
<td>Please sign</td>
</tr>
</tbody>
</table>

Name: ____________________________  Name: ____________________________
Address: ____________________________  Address: ____________________________
Home ph: ____________________________  Home ph: ____________________________
Work ph: ____________________________  Work ph: ____________________________
Mobile ph: ____________________________  Mobile ph: ____________________________
Relationship to child: ____________________________  Relationship to child: ____________________________

Details of people you authorise to collect from the program:
In the event that the child is not collected from the Service and the parents cannot be contacted, this list will be used to arrange for someone to collect your child.

Name: ____________________________  Name: ____________________________
Address: ____________________________  Address: ____________________________
Home ph: ____________________________  Home ph: ____________________________
Work ph: ____________________________  Work ph: ____________________________
Mobile ph: ____________________________  Mobile ph: ____________________________
Relationship to child: ____________________________  Relationship to child: ____________________________

Name: ____________________________  Name: ____________________________
Address: ____________________________  Address: ____________________________
Home ph: ____________________________  Home ph: ____________________________
Work ph: ____________________________  Work ph: ____________________________
Mobile ph: ____________________________  Mobile ph: ____________________________
Relationship to child: ____________________________  Relationship to child: ____________________________
**Child’s medical information:**

<table>
<thead>
<tr>
<th>Response</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your child have any special needs?</td>
<td>Yes ☐ No ☐ (please tick)</td>
</tr>
<tr>
<td>If yes</td>
<td>Please provide details of any special needs and any management procedure to be followed with respect to the special need.</td>
</tr>
</tbody>
</table>

Does the child have a developmental delay or disability including intellectual, sensory or physical impairment? Yes / No

Does your child have any special consideration due to any cultural, religious or dietary requirements or additional needs? Yes / No

Does your child have any allergies or sensitivity? Yes ☐ No ☐ (please tick)

- Penicillin ☐
- Aspirin ☐
- Band-Aids ☐
- Bee Stings ☐
- any food (please list food) ☐

If yes, please provide details of any allergies and any management procedure to be followed with respect to the allergy.

**Anaphylaxis/Allergies:**

Does your child have any known Allergies or Anaphylaxis

If yes, what causes the allergies

Has your child been diagnosed at risk of anaphylaxis? No ☐ Yes ☐

Does your child have an auto injection device (eg EpiPen)? No ☐ Yes ☐

In order to proceed with this enrolment a current action plan is required, sign, stamped and dated by a G.P. Medication and/or EpiPen must be kept at the service.

**Asthma:**

Does your child have Asthma.

If Yes, in order to proceed with this enrolment a current action plan is required, sign, stamped and dated by a G.P. Medication must be kept at the service.

**Diabetes:**

Does your child have diabetes:

If yes Please provide a current medical plan provided by the child’s Doctor. The plan needs to be signed, stamped, and dated with a passport size coloured recent photo of your child.

Does your child have **any other medical condition**: epilepsy, diabetes, dizzy spells,

Does the child have any dietary restrictions? No ☐ Yes ☐ (please tick)

If yes, the following restrictions apply:
Court Orders, Parenting Orders and or Parenting Plans:
Are there any court orders, parenting orders and or parenting plans relating to the powers, duties, responsibilities or authorities of any person in relation to the child or access to the child?

☐ No ⇒ go to the next section.  ☐ Yes ⇒ please complete the following:

1. Bring the original court orders, parenting plans and or parenting plans for staff to see and a copy to attach to this enrolment form;

2. If these orders:
   a) change the powers of a parent/guardian to:
      • authorise the taking of the child outside the service by a staff member of the service;
      • in the case of a family day care service, the taking of the child outside the family day care venue by a family day carer;
      • consent to the medical treatment of the child;
      • request or permit the administration of medication to the child;
      • collect the child from the service or family day care, AND/OR
   b) give these powers to someone else

then describe these changes and provide the contact details of any person given these powers below:

Permission:

<table>
<thead>
<tr>
<th>To use:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunscreen: yes / no</td>
<td></td>
</tr>
<tr>
<td>Zinc Cream: yes / no</td>
<td></td>
</tr>
<tr>
<td>Hair Spray: yes / no</td>
<td></td>
</tr>
<tr>
<td>Face Paint: yes / no</td>
<td></td>
</tr>
<tr>
<td>Photo’s display at OSHC: yes / no</td>
<td></td>
</tr>
<tr>
<td>Photo’s (newsletter/local paper/display): yes / no</td>
<td></td>
</tr>
<tr>
<td>Permission to watch PG movies: yes / no</td>
<td></td>
</tr>
</tbody>
</table>

Additional information about your child.

Is there is anything else that the children’s service should know about the child? (Egg excessive fears, favourite activities, attending other early childhood service)

..........................................................................................................................
..........................................................................................................................
..........................................................................................................................
..........................................................................................................................
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..........................................................................................................................
**Child’s immunisation record:**

Has the child been immunised? No ☐ Yes ☐ (please tick)

*If yes, provide the details by:
- attaching a copy of the Immunisation Record printout from local government OR
- attaching the Child History Statement from the Australian Childhood Immunisation Register..

Please complete the table below:

<table>
<thead>
<tr>
<th>Immunisation (valid from March 2008)</th>
<th>Birth</th>
<th>2 months</th>
<th>4 months</th>
<th>6 months</th>
<th>12 months</th>
<th>18 months</th>
<th>4 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Diphtheria, tetanus and cellular pertussis (Dtpa)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Haemophilic influenza (Type b)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Inactivated poliomyelitis (IPV)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Pneumococcal conjugate (7vPCV)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Measles, mumps and rubella (MMR)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Meningococcal C</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Varicella (VZC)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Additional immunisations for Aboriginal and Torres Strait Islander children (if required)

<table>
<thead>
<tr>
<th></th>
<th>12-24 months</th>
<th>18-24 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Pneumococcal polysaccharide (23vPPV)</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**ENROLMENT DETAILS:**

**HOURS TO ATTEND CENTRE**

Opening Hours
Before Care 6.45am - 8.45am  After Care 3.30pm - 6.15pm

Requested date to start care: __________________________

Type of care required:  Before ☐  after ☐  Casual ☐

<table>
<thead>
<tr>
<th>Before care (am)</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>After care (pm)</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Do you have siblings attending other funded care?  Yes ☐  no ☐

If yes how many? __________  Name of Child /Children ___________________________ Date of Birth__________

*(Please do not include the children attending this care)*
Declaration and consent to emergency medical treatment

I, (Print full name) ........................................................................ a person 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;

agree to collect or make arrangements for the collection of the child referred to in this enrolment form
if s/he becomes unwell at the service;

consent to the proprietor or in the case of a family day care, the family day care service to seek
medical treatment for the child from a medical practitioner, hospital or ambulance service.

Signature................................................................. Date..............................................

CCTV monitoring system

Parents are advised that the school operates a CCTV monitoring system at the entrance and exit doors of the Out of School
Hours Care program. This system improves risk management and the personal safety of students, staff and visitors using
the service.

Confidentiality of enrolment records

The proprietor of the children’s service must ensure that information in the child’s enrolment record is not divulged
to another person unless necessary for the care or education of the child, to manage medical treatment of the child, where
expressly authorised by the parent.

Guardians

A guardian of a child also has lawful authority. A legal guardian is given lawful authority by a court order. The definition of
"Guardian also covers situations where a child does not live with his or her parents and there are no court orders.
. In these cases, the guardian is the person the child lives with who has day-to-day care and control of the child.

Definition of Parenting Orders and Parenting Plans.

Parenting Orders means a parenting order within the meaning of section 64B (1) of the Family Law Act 1975
(Commonwealth.)

Parenting Plan means a parenting plan within the meaning of section 63C (1) of the Family Law Act 1975 includes a
registered parenting plan within the meaning of section 63C (6) of that Act

Proprietors are reminded of their requirement to comply with the Information Privacy Act 2000, which requires a Privacy Collection
Statement to accompany any enrolment form