OUTSIDE SCHOOL HOURS CARE ENROLMENT FORM

Port Noarlunga OSHC and Vacation Care Services
10 James Street, Port Noarlunga SA 5167
Phone: 83822455 Fax: 83263530
Mobile: 0405 334 676

CHILD INFORMATION

Family Name: _____ First Name: _____
Preferred Name: _____ Gender: _____
Date of Birth: _____/_____/_____ CRN: _____
Address: _____
_____Post Code: _____

ENROLLING PARENT / GUARDIAN AND BILLING DETAILS

Family Name: _____ First Name: _____
Gender: _____ Date of Birth: _____
Contact Priority: _____ CRN: _____
Address: _____
_____Post Code: _____
Relationship to child: _____ Home Phone: _____
Mobile Phone: _____ Work Phone: _____
Email address: _____

OTHER PARENT / GUARDIAN (IF APPLICABLE)

Family Name: _____ First Name: _____
Gender: _____ Date of Birth: _____
Contact Priority: _____ CRN: _____
Address: _____
_____Post Code: _____
Relationship to child: _____ Home Phone: _____
Mobile Phone: _____ Work Phone: _____
Email address: _____

PARENTING PLANS/ORDERS RELATING TO THIS CHILD

Please provide information on current parenting plans or orders relating to the child you are enrolling.

_____
_____
_____
_____
_____

CARE ELSEWHERE

I am claiming Childcare Benefit (CCB) at other approved Child Care Service/s (which includes LDC, OSHC, FDC, IHC, OCC) Yes ☐ No ☐ Number of children _____

EMERGENCY CONTACTS

Family Name: _____ First Name: _____
Contact Priority: _____ Home Phone: _____
Mobile Phone: _____ Work Phone: _____
Address: _____
_____Post Code: _____
Relationship to child: _____

EMERGENCY CONTACTS

Family Name: _____ First Name: _____
Contact Priority: _____ Home Phone: _____
Mobile Phone: _____ Work Phone: _____
Address: _____
_____Post Code: _____
Relationship to child: _____

It is very important that you tell these people you have nominated them. In nominating them you give them the 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 in an emergency until he/she can be returned home.

COLLECTION AUTHORITIES

Family Name: _____ First Name: _____
Home Phone: _____ Mobile Phone: _____
Work Phone: _____ Relationship to child: _____

Family Name: _____ First Name: _____
Home Phone: _____ Mobile Phone: _____
Work Phone: _____ Relationship to child: _____

Family Name: _____ First Name: _____
Home Phone: _____ Mobile Phone: _____
Work Phone: _____ Relationship to child: _____

The people nominated here have been given approval only to collect the child and should not be contacted in case of emergency.

MEDICAL AND HEALTH INFORMATION

Has the child received all immunisations appropriate for his/her age? Yes ☐ No ☐ (Please tick)
If no, please provide details: _____
_____
_____
I accept full responsibility if my child is not immunised. Parent/Guardian Signature: _____

Has the child any conditions / mediations that be affected by OSHC activities? Yes ☐ No ☐ (Please tick)
If yes, please give specifics and provide details of related medication: _____
_____
_____
_____

Has the child any additional / special needs? Yes ☐ No ☐ (Please tick)
If yes, please give specifics and provide details of related medication: _____
_____
_____
_____

Does the child require special aids (eg. Glasses, hearing aids)? Yes ☐ No ☐ (Please tick)
If yes, please provide details: _____
_____
_____
_____

MEDICAL AND HEALTH INFORMATION (Continued)

Has the child any special dietary needs not related to allergies? Yes ☐ No ☐ (Please tick)
If yes, please provide details: _____
_____
_____
_____

Has the child had any kind of allergic reaction (eg. foods, medication)? Yes ☐ No ☐ (Please tick)
If yes, please provide details including reaction, treatment and medications:_____
_____
_____
_____
_____
_____
_____

Has the child suffered any illness that may re-occur (eg. chronic ear infection)? Yes ☐ No ☐ (Please tick)
If yes, please provide details: _____
_____
_____
_____

Is there any other medical that we may need to know? Yes ☐ No ☐ (Please tick)
If yes, please provide details: _____
_____
_____
_____

Is there any other personal information that we may need to know? Yes ☐ No ☐ (Please tick) *This includes religious or cultural practises/prohibitions that you would like the service to know or comments on homework, behaviour management etc.*
If yes, please provide details: _____
_____
_____
_____

Please supply the OSHC service with required medications in the original containers with child's name clearly marked. Please complete a 'permission to administer medication form' together with any medication records where necessary.

Usual Medical Attendant

Doctor's Name: _____ Phone No: _____
Clinic Name and Address: _____
_____

Usual Dental Attendant

Dentist's Name: _____ Phone No: _____
Clinic Name and Address: _____
_____

Medical Benefits cover with: _____
Ambulance Cover with:_____
Medicare No: _____ Health Care Card No: _____

GENERAL CONSENTS

- I consent for my child to take part in supervised walking excursions with the local area as part of the Centre's program.
- I consent for my child to be photographed and for their image and name to be published in circumstances the Director of the service deems to be appropriate.
- I consent for the service to apply sunblock to my child if required.
- I give consent for Centre staff to apply insect repellent to my child if required.
- I give consent for the service to call an ambulance if the Director deems it necessary for my child's wellbeing.
- I give my permission for child to watch a PG rated video at the discretion of the service Director.
- I give my permission for my child to use the skateboarding equipment and scooters during OSHC and Vacation Care. The equipment will be used in conjunction with adult supervision and afety gear.

AGREEMENTS

- I agree to pay the $50 bond and required fees for my child's booked childcare hours and accept the policies and rules of the Port Noarlunga Primary School OSHC Service.
- I agree that the staff of the service may administer basic first aid to my child if the need arises.
- I understand that if at any time the staff of the service consider that my child requires emergency medical / hospital / ambulance assistance , that they will have the local medical / hospital / ambulance attend my child. I acknowledge that I be liable for any medical / hospital / ambulance expences uncured 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 the OSHC Service if any of these details change.

Signature of Parent / Guardian: _____Date: _____/_____/_____
Interviewed / Accepted by: _____ Date: _____/_____/_____

Please provide details of the booking arrangements you wish to make. We understand that these may change at times and require 24 hours notice of cancellation. If you wish to make further bookings please contact the school on 83822455 or the OSHC Service on 0405 334 676.

Before School Care

Monday	Tuesday	Wednesday	Thursday	Friday
Arrive: am	Arrive: am	Arrive: am	Arrive: am	Arrive: am
Depart: am	Depart: am	Depart: am	Depart: am	Depart: am

Dates: _____ or ongoing ☐ (Please tick)

After School Care

Monday	Tuesday	Wednesday	Thursday	Friday
Arrive: pm	Arrive: pm	Arrive: pm	Arrive: pm	Arrive: pm
Depart: pm	Depart: pm	Depart: pm	Depart: pm	Depart: pm

Dates: _____ or ongoing ☐ (Please tick)

Vacation Care

Monday	Tuesday	Wednesday	Thursday	Friday
Arrive: am/pm	Arrive: am/pm	Arrive: am/pm	Arrive: am/pm	Arrive: am/pm
Depart: am/pm	Depart: am/pm	Depart: am/pm	Depart: am/pm	Depart: am/pm

Dates: _____ or ongoing ☐ (Please tick)