BLACKWOOD PRIMARY OSHC: ENROLMENT FORM

CHILD/REN INFORMATION

Family Name	**Family Name**	**Family Name**
Child's Name and middle name	**Child's Name and middle name**	**Child's Name and middle name**
GENDER: Male / Female	**Male / Female**	**Male / Female**
Child's Centrelink Reference No.	**Child's Centrelink Reference No.**	**Child's Centrelink Reference No.**
Medicare No: **Reference No. For child:**	**Medicare No:** **Reference No. For child:**	**Medicare No:** **Reference No. For child:**
Address **P/C**	**Address (If different to child 1)** **P/C**	**Address (If different to other children)** **P/C**
Birth Date	**Birth Date**	**Birth Date**
Language spoken at home: **Other languages spoken/known:** **Cultural Background of child/parents:**	**Language spoken at home:** **Other languages spoken/known:** **Cultural Background of child/parents:**	**Language spoken at home:** **Other languages spoken/known:** **Cultural Background of child/parents:**
Medical Condition/s: **Allergies:** **(eg at risk of anaphylaxis)** **Medic Alert Number:** **(If applicable)**	**Medical Condition/s:** **Allergies:** **(eg at risk of anaphylaxis)** **Medic Alert Number:** **(If applicable)**	**Medical Condition/s:** **Allergies:** **(eg at risk of anaphylaxis)** **Medic Alert Number:** **(If applicable)**
Specials Needs/Special Aids **(eg Glasses, Hearing aids)**	**Specials Needs/Special Aids**	**Specials Needs/Special Aids**
Dietary Requirements:	**Dietary Requirements:**	**Dietary Requirements:**
Is immunisation status current? Y / N **If no, please give details:**	**Is immunisation status current? Y / N** **If no, please give details:**	**Is immunisation status current? Y / N** **If no, please give details:**

**Specific details of medical and special needs must be provided on additional Medical forms or on a Health Support Plan. If your child requires medication the service requires a "Mediation Authority" from the child's medical practitioner. See staff for relevant forms if needed. (Eg specific forms for asthma, epilepsy, anaphylaxis, diabetes, toileting, etc.) Families must check and update annually.*

PARENT/CAREGIVER INFORMATION

1. Name **Gender: M / F**	**2. Name** **Gender: M / F**
D.O.B: Required for CCB purposes	**D.O.B.** Required for CCB purposes
Centrelink Reference No. Required for CCB purposes	**Centrelink Reference No** Required for CCB purposes
Address (If different from children above) **P/C**	**Address** (If different from children above) **P/C**
Home Ph	**Home Ph**
Mobile	**Mobile**
Email	**Email**
Work Place **Address** **Work Ph**	**Work Place** **Address** **Work Ph**

- Which parent/guardian is responsible for dealing with the Department of Human Services for Childcare Benefit and has been assessed for CCB eligibility? _____
- Who will be responsible for the OSHC Account:

( ) Person 1 ( ) Person 2 ( ) Both 1 and 2 ( ) Separate Account for each person

Doctor's Name:_____Ph:_____
Clinic:_____ Address:_____
Ambulance Cover: **YES / NO** Private Health Insurance: **YES / NO** Which fund:_____

Are there any Family Court Orders, parenting orders, parenting plans, restraining orders? **YES / NO**
(If Yes, please attach a copy of the order/s and other relevant information)

Details:_____
Any other information or special considerations relevant to the child/ren: e.g. Religious or cultural practices, concerns, special needs, etc:

_____

EMERGENCY CONTACTS (In addition to parents/guardians)

Please ensure you have some contacts close to the school so that children can be collected quickly in an emergency or if parents/carers are unable to collect children by 6.00 p.m. Please inform these contacts that you have provided OSHC with their details. In nominating these people you give them the authority to collect and care for your child/ren if neither parent/caregiver can be contacted.

Name	**Name**	**Name**
Address	**Address**	**Address**
Home Ph **Work Ph** **Mobile**	**Home Ph** **Work Ph** **Mobile**	**Home Ph** **Work Ph** **Mobile**
Relationship to child/ren:	**Relationship to child/ren:**	**Relationship to child/ren:**
Have permission by parents to: • **Be notified of an emergency involving the children if parents cannot be contacted YES / NO** • **Collect child/ren from service YES / NO** • **Consent to medical treatment or authorise administration of medication YES / NO** • **Authorise Educators to take children out of service (eg excursions) YES / NO**	**Have permission by parents to:** • **Be notified of an emergency involving the children if parents cannot be contacted YES / NO** • **Collect child/ren from service YES / NO** • **Consent to medical treatment or authorise administration of medication YES / NO** • **Authorise Educators to take children out of service (eg excursions) YES / NO**	**Have permission by parents to:** • **Be notified of an emergency involving the children if parents cannot be contacted YES / NO** • **Collect child/ren from service YES / NO** • **Consent to medical treatment or authorise administration of medication YES / NO** • **Authorise Educators to take children out of service (eg excursions) YES / NO**

Authorised Nominees: Permission by parents to collect child/ren from service (In Addition to people listed above)

Name **1.**	**Address**	**Phone Numbers:**	**Relationship to child/ren**
2.			
3.			

AUTHORISATONS:

I give permission for OSHC staff to exchange information relating to my child with school staff and to appropriate person(s) e.g. In an emergency (SA Ambulance, SAPOL) or pertaining to the special needs of my child/children. **Yes / No**

I give permission for my child/children to participate in photographic, video and electronic media displays that promote the activities within the Service. **Yes / No / Photographic Only**

I consent to photographs of my child/ren being placed on the Internet. (School or DECD sites) **Yes / No**

I consent to my child/ren's work being published in newsletters/displayed in the OSHC area. **Yes / No**

I am aware that a person listed on this enrolment form must sign the child/ren In at Before School Care and Out at After School Care for each occasion of attendance. **Yes / No**

I am aware that I may be eligible to receive Child Care Benefit and Childcare Rebate and it is my responsibility to contact the Department of Human Services and provide date of births and reference numbers to OSHC. **Yes / No**

I am aware that I need to collect my fee statement / tax invoice regularly from my family pocket at OSHC and agree to make regular payments: **Weekly Fortnightly In Advance** (please circle preferred schedule)

I would prefer my weekly statement to be emailed to the address provided: **Yes / No**

I am aware that failure to make regular child care payments will result in my child/ren's exclusion from the Service. **Yes / No**

I certify that the information on this form is true and correct. I will inform the Service if any of these details change. I agree to comply with the OSHC policies and procedures as outlined in the Family Handbook. I am aware that the service has a number of Policies and Procedures in place that are available for viewing on request.

I authorise the approved provider, nominated supervisor or an educator of Blackwood OSHC service, to seek medical treatment for the child/ren listed on this enrolment form, by a registered medical practitioner, hospital or ambulance service (including transportation by ambulance). I am aware that in the event of my child/ren requiring medical treatment, the staff will access the SA Ambulance Service if deemed necessary and that I will be responsible for any costs incurred.

Parent/Caregiver Name:_____ **Signature:** _____ **Date**:_____

Parent/Caregiver Name:_____ **Signature:** _____ **Date**:_____

OSHC STAFF:
Interviewed by: _____ **Signature:** _____ **Date:** _____

(Updated November 2013)