CONFIDENTIAL: RESTRICTED ACCESS

☐ Flexible / Casual ☐ Fixed / Routine

Sturt Street Community School OSHC

Enrolment Form: Part 1

*** Please complete all sections or designate as not applicable (N/A).**

221-239 Sturt St, Adelaide SA 5000, AU
Ph: 8231 7990
Fax: 08 82313188
oshc.sscs770@schools.sa.edu.au

CHILD

Family Name: Gender: F / M

First Name(s): Known as:

Date of birth: __ /__ /____ CRN:

Address No. / Street: Town/ Suburb:

Postcode: Primary Language:

Indigenous status: Aboriginal: Yes / No TS Islander: Yes / No

ELIGIBLE PARENT/GUARDIAN & BILLING DETAILS

Name:

Date of birth: __ /__ /____ CRN:

Relationship to child: Contact Priority: ☐ Primary Language:

Address: (h)

(w)

Phone: (h) (w) (m)

Email:

OTHER PARENT/GUARDIAN (if applicable)

Name:

Relationship to child: Contact Priority: ☐ Primary Language:

Address: (h)

(w)

Phone: (h) (w) (m)

Email:

PARENTING PLANS / ORDERS relating to this child

EMERGENCY CONTACTS & COLLECTION AUTHORITIES

Name: Contact Priority: ☐

Address: Relationship to child:

Phone: (h) (w) (m)

Name: Contact Priority: ☐

Address: Relationship to child:

Phone: (h) (w) (m)

N.B. It is very important that you tell these people that you have nominated them. In nominating them you give them 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 until s/he can be returned home.

COLLECTION AUTHORITIES ONLY

Name:

Address: Relationship to child:

Phone: (h) (w) (m)

Name:

Address: Relationship to child:

Phone: (h) (w) (m)

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

Enrolment Form: Part 2

Child's Name:

MEDICAL AND HEALTH INFORMATION

Has the child received all immunisations appropriate for her/his age? Yes / No

If no, please give details:

Has the child received the following immunisations? (please tick):

	10 - 15 years
Diphtheria	☐
Tetanus	☐
Pertussis (Whooping Cough)	☐
Human Papillomavirus (HPV)	☐

I accept full responsibility if my child is not immunised.

Parent / Guardian signature:

Has the child any conditions / medications that may be effected by OSHC activities?

If yes, please give specifics and any related medication:

Has the child any disabilities? Yes / No Effective date: __/__/____

If yes, please record specifics:

Has the child any special needs? Yes / No Effective date: __/__/____

If yes, please record specifics:

Does the child usually require special aids (e.g. glasses, hearing aid etc.)?

If yes, please give details:

Has the child any special dietary needs not related to allergies?

If yes, please give specifics:

Has the child suffered any illness that may re-occur (e.g. chronic ear infection)?

If yes, please give details:

Has the child had any kind of allergic reactions or food intolerances?

Foods:	Reaction / Medication:

Penicillin:	Reaction / Medication:

Others:	Reaction / Medication:

Is there any other medical information we might need to know?

Note: Please supply the service with required medications in original containers with the 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:

Address:

Usual Dental attendant

Dentist's name: Phone No.:

Clinic name:

Address:

Medical Benefits cover with:

Ambulance cover with:

Medicare number: Health Care Card number:

Enrolment Form: Part 3

Child's Name:

BOOKINGS

BSC	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Arrive:							
Depart:							

From: __/__/____ for: ____ weeks / or until: __/__/____ or Ongoing (tick) ☐

ASC	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Arrive:							
Depart:							

From: __/__/____ for: ____ weeks / or until: __/__/____ or Ongoing (tick) ☐

VAC	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Arrive:							
Depart:							

From: __/__/____ for: ____ weeks / or until: __/__/____ or Ongoing (tick) ☐

IS THERE ANYTHING MORE WE NEED TO KNOW?

(e.g. 1. any personal, religious or cultural practices/prohibitions that you would like the service to know or 2. comments on homework, behaviour management etc.)

CONSENTS

Please initial next to each item to which you consent.

I consent to paying the OSHC fees as per the policy which I've read in the handbook. I am aware of the cancelation period required, as outlined in the OSHC policies. ____

I consent for my child to be photographed and for their image and name to be published in circumstances the Director deems to be appropriate. ____

I consent for Centre staff to apply sunblock to my child if required. ____

I give consent for my child to be taken by a staff member to the local hospital or doctor's surgery in the event of a minor injury. ____

AGREEMENTS

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

I agree that the staff of the Service may administer simple 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, they will have the local medical/ hospital/ambulance attend my child. 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 the Service if any of these details change.

Parent / Guardian signature: _____ Date: __/__/____

sighted a child health record (tick) ☐

Interviewed / Accepted by: _____ Date: __/__/____