

Sturt Street Community School OSHC

221-239 Sturt Street ADELAIDE
SA 5000
8231 7990

Casual Enrolment:
 Full Enrolment:

Enrolment Form: Part 1

CHILD

Family Name: Gender:

First Name(s): Known as:

Date of birth: CRN:

Address No. / Street:

Town/Suburb: Postcode:

Indigenous status: Aboriginal: TS Islander:

PARENTING PLANS / ORDERS relating to this child

ENROLLING PARENT/GUARDIAN & BILLING DETAILS

Name:

Date of birth: CRN:

Relationship to child: Contact Priority:

Address: (h)
(w)

Phone: (h) (w) (m)

Email:

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.

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:

OTHER PARENT/GUARDIAN (if applicable)

Name:

Relationship to child: Contact Priority:

Address: (h)
(w)

Phone: (h) (w) (m)

COLLECTION AUTHORITIES ONLY

Name: Relationship to child:

Address:

Phone: (h) (w) (m)

Name: Relationship to child:

Address:

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 - 13	12 - 18
	years	years
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
Varicella (Chickenpox)	<input type="checkbox"/>	<input type="checkbox"/>
Human Papillomavirus (HPV)	<input type="checkbox"/>	<input type="checkbox"/>

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?

Foods:	Reaction / Medication:
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-----	-----
-----	-----
-----	-----

Penicillin:	Reaction / Medication:
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Others:	Reaction / Medication:
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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:

