CONFIDENTIAL: RESTRICTED ACCESS

☑ Flexible / Casual ☐ Fixed / Routine

Seacliff Primary School OSHC Service
Enrolment Form: Part 1

Barwell Ave, Seacliff SA 5049, AU
Ph: 82983742 or 0414293860
seacliffoshcfinance@gmail.com

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 their age? Yes / No

If no, please give details:

I accept full responsibility if my child is not immunised.

Parent / Guardian signature:

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

	12 - 13 years
Diphtheria	☐
Tetanus	☐
Pertussis (Whooping Cough)	☐
Human Papillomavirus (HPV)	☐

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 give consent for my child to be transported by ambulance in the event of an emergency

I give concent for a blood transfusion in the case of an emergency

I have provided Seacliff Primary School OSHC with all relevant court orders relating to the powers and responsibilities of the parents in relation to the child or access to the child.

I agree to pay Seacliff Primary School OSHC for all costs incurred by Seacliff Primary School OSHC (including costs for which the Seacliff Primary School OSHC may be contingently liable) in any attempt to collect any monies owed by you to Seacliff Primary School OSHC under this Agreement including debt collection agent costs, repossession costs, location search costs, process server costs and solicitor costs on a solicitor/client basis.

I give concent for my child to watch PG rated movies and play PG rated games while at OSHC under the supervision of a staff member

I give consent for my child to be photographed/video-taped and for their image to be displayed on Seacliff Primary's website and newsletter that is made available to the school community.

I give consent for my child to be photographed/video-taped and for their image and name to be displayed within the OHSC room and used for documentation.

I give consent to OSHC providing my child/ren with sunscreen when the UV index is rated 3 or higher

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:** _ _ / _ _ / _ _ _ _