

**Coburg West Primary School
Out of School Hours Childcare Program**

Enrolment Form

This document will be reviewed 3 years from the date of issue/review.

Please complete all sections of this form using **BLOCK LETTERS**. The information provided MUST be the same as what is provided to centrelink. Enrolment Date: _____

Section 1: Child's Details

Child's:	_____	_____	_____
	<i>First Name</i>	<i>Middle Name</i>	<i>Surname</i>
Date of birth:	_____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:	_____		
Parent / Caregiver Email:	_____		
CRN No.	_____	Child's Grade Level	_____
Child's:	_____	_____	_____
	<i>Birth Country</i>	<i>Language spoken at home</i>	<i>Religion</i>
Is this child of Aboriginal or Torres Strait Islander decent? <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> No			

Section 2: Child's Medical Details

Family Doctor:	_____	_____	_____
	<i>Name</i>	<i>Address</i>	<i>Contact Number</i>
Medicare Number	_____		
Ambulance Subscription:	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes, provide subscription No.) _____	
Private Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fund Name:	_____
	Membership Number: _____		
Does this child have any allergies or sensitivities?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes please specify by ticking the boxes below)		
Does this child have Anaphylaxis?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Action plan attached	
Does this child have Asthma?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Action plan attached	
Does this child have any other medical conditions or needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes please specify)		

Does this child have a developmental delay or disability including intellectual, sensory or physical impairment?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes please specify)
Please specify if your child has any dietary restrictions eg: (cultural/religious).	
I give permission for the program to display photos of my child in relation to allergies and any medical conditions.	
<input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes please specify)	

IMPORTANT!: IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE PROVIDE A PHOTO OF YOUR CHILD AND ANY RELEVANT DOCUMENTATION. IN ADDITION A RISK MINIMISATION PLAN WILL NEED TO BE COMPLETED.

Section 3: Immunisation Details

Has this child been immunised? Yes No

PLEASE NOTE:

(If Yes provide copy of immunisation certificate)

Attached

Section 4: Other Details

Is there any other relevant information that the staff need to be aware of when caring for your child? i.e fears, concerns

Section 5: Parent / Caregiver Details (This is the Parent who is registered with Centrelink for Childcare benefit)

Parent / Caregiver:	_____	_____
	<i>First Name</i>	<i>Surname</i>
Address:	_____	Post code: _____
Parent / Caregiver Email:	_____	
Contact Numbers:	_____	_____
	Home	Mobile
	_____	Work
Parent / Caregiver:	_____	_____
	<i>Birth Country</i>	<i>Language spoken at home</i>
	_____	<i>Religion</i>
Date of birth:	_____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	_____	_____
	<i>Occupation</i>	<i>Place of Employment</i>
Address of Employment:	_____	Post code: _____
Parent / Caregiver CRN No.	_____	
Do you require help reading English? (in relation to the program)		
<input type="checkbox"/> Yes <input type="checkbox"/> No		

Section 6: Parent / Caregiver Details

Parent / Caregiver:	_____	_____
	<i>First Name</i>	<i>Surname</i>
Address:	_____	Post code: _____
Parent / Caregiver Email:	_____	
Contact Numbers:	_____	_____
	Home	Mobile
	_____	Work
Parent / Caregiver:	_____	_____
	<i>Birth Country</i>	<i>Language spoken at home</i>
	_____	<i>Religion</i>
Date of birth:	_____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	_____	_____
	<i>Occupation</i>	<i>Place of Employment</i>
Address of Employment:	_____	Post code: _____

Section 7: Court Orders Relating to Child

Are there any Court Orders relating to the powers and responsibilities of the parent / caregiver in relation to the child or access to the child?

Yes No

(If Yes provide copy of Court Order) Attached
Original MUST be sighted.

Section 8: Siblings in other care where Childcare Benefit is received from Centrelink

Child's:

_____ Name

_____ Date of Birth

_____ CRN

Centre:

Child's:

_____ Name

_____ Date of Birth

_____ CRN

Centre:

Section 9: Reason for requiring care

Priority of access:

- First Priority:** A child at risk of serious abuse or neglect
- Second Priority:** A child of a single parent who satisfies or of parents who both satisfy the Work / Training / Study Test under Section 14 of the Family Assistance Act. Second priority also goes to siblings of current users.
- Third Priority:** Children of families with other commitments (family, social etc.)
- Fourth Priority:** Any other child

Will you be registering with Centrelink? Yes No

Service Provider Code: 555 010 650L

Section 10: Usage Requirements

	<u>Before Care</u>	<u>After Care</u>
What type of booking is required?	<input type="checkbox"/> Permanent <input type="checkbox"/> Casual	<input type="checkbox"/> Permanent <input type="checkbox"/> Casual
Which days are required?	<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday	<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday

Section 11: Emergency Contacts (Exclude parents / caregivers from this list)

Emergency contacts are people who are nominated to collect your child/ren from the program on your behalf. Emergency contacts need to be people who live within a 30 minute drive or closer to the school.

	First Contact	Second Contact	Third Contact
Relationship to child			
Name			
Address			
Home Phone			
Mobile			
Work Phone No.			
Tick for authorisations	<input type="checkbox"/> Emergency <input type="checkbox"/> Medical <input type="checkbox"/> Excursion	<input type="checkbox"/> Emergency <input type="checkbox"/> Medical <input type="checkbox"/> Excursion	<input type="checkbox"/> Emergency <input type="checkbox"/> Medical <input type="checkbox"/> Excursion

In case of an accident or injury being sustained by my child, I authorise the relevant emergency contacts above, where it is impracticable to communicate with me, to arrange emergency medical, surgical treatment or administration of medicine as may be deemed necessary. Including transportation of my child to hospital by ambulance. I accept that I will be responsible for any costs incurred.

SIGNATURE _____ DATE _____

Section 12: Declaration and Consent to Emergency Medical Treatment

I, (Please print full name), the authorized Parent or Caregiver of the child named on this **Enrolment Form**.

- ❖ Declare that the information in this **Enrolment Form** is true and correct and I will immediately notify the Out of School Hours program of any changes to this information;
- ❖ Agree to collect or make arrangements for the collection of my child referred to in this **Enrolment Form** if he / she becomes unwell;
- ❖ In case of an accident or injury being sustained by my child, I authorise the relevant Program Co-ordinator or Delegate of the Out of School Hours Childcare Program, where it is impracticable to communicate with me, to arrange emergency medical or anaesthetics, blood transfusions and surgical treatments or operations as may be deemed necessary. Including the transportation of my child to hospital by ambulance. I accept that I will be responsible for any costs incurred.

Parent / Caregiver _____
Signature Date

Witness (Program co-ordinator) _____
Signature Date

Section 13: General Permission

Please tick to acknowledge your permission for the following:

- For the Program to display information regarding your child, within the Program only. This information will only be used to assist the Program staff with the care of your child in relation to Allergies, Special Needs Etc.
- For the Program to take your child off the premises in case of emergency

Parent / Caregiver _____
Signature Date

Section 14: Cultural / Religious (This section is optional)

To assist the staff in the Program to help the children celebrate diversity in our community we are asking if there are any Cultural / Religious Festivals or Celebrations that you would like us to share with your child. Please provide us with the information regarding these cultural celebrations.

Section 15.1: IT Permission

I give permission for my child to watch G rated movies only (please circle) Yes or No

I give permission for my child to watch PG rated movies (please circle) Yes or No

I give permission for my child to access the internet and follow a Code of Practice, monitored by staff (10 minute limit on all devices). (please circle) Yes or No

I give permission for my child to access offline iPad games monitored by staff (10 minute limit on all devices). (please circle) Yes or No

Section 15.2: OSHC Photographs

During the year staff take photographs of the children participating in various activities. The photos taken are either placed on display in the OSHC Program or on the private OSHC SeeSaw page.

Tick for authorisation:

- Private OSHC SeeSaw
- OSHC program

Section 15.3: External Photographs

During the year photographs of your child may be taken by other parents and external organisations. The OSHC program will have no control over the use of the photos/video taken by other families, friends and other organisations.

I give permission for my child to be included in photos/videos for the purposes stated above.

Yes or No

Section 15.4 Birthday's

I give permission for my child's name and birth date to be displayed on the OSHC program Birthday calendar. Yes or No

Section 15.5 SUNSCREEN/BAND AIDS

I give permission for the Out of School Care Program to apply SPF (Anti-Cancer Council Sunscreen) to my child.

Yes or No

I give permission for the Out of School Care Program to apply a Band Aid (Coles Medistrips latex free) to my child.

Yes or No

Section: 16: Privacy Statement

The Coburg West Out of School Hours Program uses the enrolment form to collect personal information for the purposes of service enrolment and statistical recording. The information may be shared with funding agencies and administrators for operational purposes only. The information will not be disclosed to any other party except as required by law. You are able to amend or correct information on request, by contacting the service coordinator.

Section 17: Parent/Caregiver Consent

I give permission for the program to take action as indicated above.

Name of Parent/Caregiver: _____

First Name

Surname

Signature

Date

Updated June 2021