MEREDITH PRIMARY SCHOOL

OUTSIDE SCHOOL HOURS CARE PROGRAM

5 Wallace Street, Meredith 3333 Telephone 5286 1313

ENROLMENT FORM

Please complete ALL INFORMATION on ALL SIDES of this application in BLOCK LETTERS

Centrelink Reference Number for this family: | | | | - | | | | - | | | | |

This enrolment application will not be processed unless a Centrelink Reference Number is clearly indicated here. Call the Family Assistance Office on 1361 50 to get your number if you do not have it. If you DO NOT intend to claim Child Care Benefit as reduced fees, we still require your Centrelink Reference Number to comply with government reporting requirements.

PARENT / LEGAL GUARDIAN DETAILS (this must be the person whose reference number is listed above)

Name: ..... Relationship to Child/ren: ..... Date of Birth: ...../...../.....

Address: ..... Suburb:..... Post Code: .....

Home Phone: ..... Mobile Phone: ..... Work Phone: .....

Email address:.....

Do you give permission for the Outside School Hours Care Program to contact you by SMS on your mobile? YES / NO

Are you responsible for fee payment? YES / NO Does the child live with this parent / legal guardian? YES / NO

If No, please provide details of the responsible person / agency .....

OTHER PARENT / LEGAL GUARDIAN DETAILS

Name: ..... Relationship to Child/ren: ..... Date of Birth: ...../...../.....

Address: ..... Suburb:..... Post Code: .....

Home Phone: ..... Mobile Phone: ..... Work Phone: .....

Do you give permission for the Outside School Hours Care Program to contact you by SMS on your mobile? YES / NO

Are you responsible for fee payment? YES / NO

If No, please provide details of the responsible person / agency .....

Does the child live with this parent / legal guardian? YES / NO

COMPULSORY ADDITIONAL EMERGENCY CONTACTS

Thee may be times when your child has an accident, injury or illness and the parent/guardian cannot be contacted. To deal with these situations we require additional emergency contacts who must be over 18 years of age.

Name: ..... Relationship to Child/ren: .....

Address: ..... Suburb:..... Post Code: .....

Home Phone: ..... Mobile Phone: ..... Work Phone: .....

Is this person authorized to collect your child/ren? YES / NO

Is this person authorized to consent to emergency medical treatment for your child/ren in your absence? YES / NO

Name: ..... Relationship to Child/ren: .....

Address: ..... Suburb:..... Post Code: .....

Home Phone: ..... Mobile Phone: ..... Work Phone: .....

Is this person authorized to collect your child/ren? YES / NO

Is this person authorized to consent to emergency medical treatment for your child/ren in your absence? YES / NO

CHILD CARE BENEFIT (please tick)

Child Care Benefit (CCB) is administered by the Family Assistance Office (FAO). The FAO is responsible for the payment of CCB across all Australian approved service types (family day care, centre based, vacation care, before /after school care programs). In order to claim CCB you will need to contact the FAO. Registering for CCB is a one off process. The FAO can be contacted on 136150 and further information can be found in their website www.familyassist.gov.au

I would like to claim CCB as reduced fees		I do not wish to claim CCB	
I would like to claim CCB as a lump sum		I have registered with the FAO to claim CCB	

BOOKING INFORMATION (Please circle the days required)

Child (1)	MON	TUES	WED	THURS	FRI	CASUAL
Child (2)	MON	TUES	WED	THURS	FRI	CASUAL
Child (3)	MON	TUES	WED	THURS	FRI	CASUAL
Child (4)	MON	TUES	WED	THURS	FRI	CASUAL

BACKGROUND INFORMATION (please circle)

I give permission for my child/ren to be photographed during the program for promotion purposes and understand photographs will not be released or used for any other purpose without my consent.	YES	NO
I give permission for my child/ren to watch or play PG rated movies and games under supervision of OSHC staff during the program.	YES	NO
I give permission for the OSHC staff to supply my child/ren with sunscreen and insect repellant and if required assist with the application.	YES	NO

Please indicate below the reason for requiring care at the OSHC Program.

Working/seeking work	YES	NO	Social	YES	NO
Studying	YES	NO	Respite	YES	NO
Are you an Aboriginal or Torres Strait Islander family?				YES	NO

Family ethnic origin:

How many children will attend other approved child care services? (eg. Long Day Care, Family Day Care, Occasional Care)

What is the primary language spoken at home?	Country of birth:

PARENT /GUARDIAN DECLARATION

I, the undersigned:

- Agree that I and any authorized contact person will present photo identification if asked to do so when my child/ren are collected
- Give permission for Outside School Hours Care Program staff to remove my child/ren from the program for behavioral or medical reasons
- Understand that personal electronic equipment (game boys, mobile phones etc) is not permitted at the Outside School Hours Care Program
- Agree that the information I have provided on this form is true and correct and undertake to immediately inform the Outside School Hours Care Program of any change to this information.
- I will comply with the OSHC Policies including the timely payment of fees and late pick up penalties. All policies are available from the office and www.meredithps.vic.gov.au
- I have read the Meredith Primary School OSHC Handbook

Name of Parent/Guardian	Signature	Date

CHILD DETAILS

Child's Name (1) ……	Child's Name (2) ……
Child's Centrelink CRN: ……	Child's Centrelink CRN: ……
Date of Birth: ……/……/……. Gender: Male / Female	Date of Birth: ……/……/……. Gender: Male / Female
Medicare No: ……Ambulance Membership Y /N	Medicare No: ……Ambulance Membership Y /N
Address of child: ……	Address of child: ……
School: …… Year Level (2013) ……	School: …… Year Level (2013) ……
Does this child have any additional needs? YES / NO	Does this child have any additional needs? YES / NO
If YES, please provide details ……	If YES, please provide details ……
……	……
……	……

COURT ORDERS

Are there any Court Orders that affect this child? If YES please attach copy of Court Orders	YES	NO	Are there any Court Orders that affect this child? If YES please attach copy of Court Orders	YES	NO

MEDICAL CONDITIONS

ANAPHYLAXIS Has this child been diagnosed at risk of Anaphylaxis? If YES you must attach a current Anaphylaxis Action Plan for this enrolment to be processed, and your child's auto injector device eg Epipen must accompany them to the program	YES	NO	**ANAPHYLAXIS** Has this child been diagnosed at risk of Anaphylaxis? If YES you must attach a current Anaphylaxis Action Plan for this enrolment to be processed, and your child's auto injector device eg Epipen must accompany them to the program	YES	NO
ASTHMA Has this child been diagnosed with Asthma? If YES, you must provided a current Asthma Management Plan.	YES	NO	**ASTHMA** Has this child been diagnosed with Asthma? If YES, you must provided a current Asthma Management Plan.	YES	NO
OTHER MEDICAL CONDITIONS Does this child have any other medical conditions? **eg Epilepsy, diabetes etc. I**f YES you must provide further details of any medical condition and attach a current Medical Action Plan	YES	NO	**OTHER MEDICAL CONDITIONS** Does this child have any other medical conditions? **eg Epilepsy, diabetes etc. I**f YES you must provide further details of any medical condition and attach a current Medical Action Plan	YES	NO
Does this child have any dietary restrictions or food intolerances? If YES, please provide further information	YES	NO	Does this child have any dietary restrictions or food intolerances? If YES, please provide further information	YES	NO
Is this child fully immunised?	YES	NO	Is this child fully immunised?	YES	NO

I authorise staff of the Outside School Hours Care Program, in the event of an accident or illness, to obtain all necessary medical/ambulance assistance and treatment from a registered medical practitioner, hospital or ambulance service for my child and agree to meet any expenses attached to such treatment.

Name of Parent/Guardian ……

Signature ……..Date ……/……../……..

I authorise staff of the Outside School Hours Care Program, in the event of an accident or illness, to obtain all necessary medical/ambulance assistance and treatment from a registered medical practitioner, hospital or ambulance service for my child and agree to meet any expenses attached to such treatment.

Name of Parent/Guardian ……

Signature ……..Date ……/……../……..

FAMILY DOCTOR INFORMATION

Name of Doctor / Medical Centre: …… Telephone: ……

CHILD DETAILS

Child's Name (3) ……

Child's Centrelink CRN: ……

Date of Birth: ……/……/……. Gender: Male / Female

Medicare No: ……Ambulance Membership Y /N

Address of child: ……..

School: …….. Year Level (2012) ……..

Does this child have any additional needs? YES / NO

If YES, please provide details ……

……..

……..

Child's Name (4) ……

Child's Centrelink CRN: ……

Date of Birth: ……/……/……. Gender: Male / Female

Medicare No: ……Ambulance Membership Y /N

Address of child: ……..

School: …….. Year Level (2012) ……..

Does this child have any additional needs? YES / NO

If YES, please provide details ……

……..

……..

COURT ORDERS

Are there any Court Orders that affect this child? If YES please attach copy of Court Orders	YES	NO

COURT ORDERS

Are there any Court Orders that affect this child? If YES please attach copy of Court Orders	YES	NO

MEDICAL CONDITIONS

ANAPHYLAXIS Has this child been diagnosed at risk of Anaphylaxis? If YES you must attach a current Anaphylaxis Action Plan for this enrolment to be processed, and your child's auto injector device eg Epipen must accompany them to the program	YES	NO
ASTHMA Has this child been diagnosed with Asthma? If YES, you must provided a current Asthma Management Plan.	YES	NO
OTHER MEDICAL CONDITIONS Does this child have any other medical conditions? **eg Epilepsy, diabetes etc. I**f YES you must provide further details of any medical condition and attach a current Medical Action Plan	YES	NO
Does this child have any dietary restrictions or food intolerances? If YES, please provide further information	YES	NO
Is this child fully immunised?	YES	NO

I authorise staff of the Outside School Hours Care Program, in the event of an accident or illness, to obtain all necessary medical/ambulance assistance and treatment from a registered medical practitioner, hospital or ambulance service for my child and agree to meet any expenses attached to such treatment.

Name of Parent/Guardian ……..

Signature ……..Date ……/……../……..

MEDICAL CONDITIONS

ANAPHYLAXIS Has this child been diagnosed at risk of Anaphylaxis? If YES you must attach a current Anaphylaxis Action Plan for this enrolment to be processed, and your child's auto injector device eg Epipen must accompany them to the program	YES	NO
ASTHMA Has this child been diagnosed with Asthma? If YES, you must provided a current Asthma Management Plan.	YES	NO
OTHER MEDICAL CONDITIONS Does this child have any other medical conditions? **eg Epilepsy, diabetes etc. I**f YES you must provide further details of any medical condition and attach a current Medical Action Plan	YES	NO
Does this child have any dietary restrictions or food intolerances? If YES, please provide further information	YES	NO
Is this child fully immunised?	YES	NO

I authorise staff of the Outside School Hours Care Program, in the event of an accident or illness, to obtain all necessary medical/ambulance assistance and treatment from a registered medical practitioner, hospital or ambulance service for my child and agree to meet any expenses attached to such treatment.

Name of Parent/Guardian ……..

Signature ……..Date ……/……../……..

FAMILY DOCTOR INFORMATION

Name of Doctor / Medical Centre: …….. Telephone: ……