Gulfview Heights Primary School OSHC

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Working together to reach new Heights

Enrolment Form

CHILD DETAILS **CASUAL/PERMANENT**

FAMILY NAME ______________________________ **FIRST NAME:** ______________________________________

PREFERRED NAME: __________________________ **GENDER: MALE/FEMALE**

DATE OF BIRTH: _____/_____/________ **CRN:** ____

RESIDENTIAL ADDRESS: ____

TOWN/SUBURB: ____ **POSTCODE:** _________________

PRIMARY LANGUAGE SPOKEN AT HOME: ____

DOES THE STUDENT IDENTIFY AS BEING OF ABORIGINAL OR TORRES STRAIT ISLANDER DESCENT?

No **Yes, Aboriginal Descent** **Yes, Torres Strait Islander Descent**

IS THE CHILD IN STATE CARE? No **Yes**

Enrolling Parent/Guardian Information (Account Holder)

Name: _________________________________ **Relationship to child:** ________________ **D.O.B:** __________

Address: ____ **Postcode:** ______________

Home Phone: ___________________ **Mobile Phone:** _____________________ **Work:** ___________________

Email: ____ **CRN:** __________________________________

Parent/Guardian Details

Name: _________________________________ **Relationship to child:** ________________ **D.O.B:** __________

Address: ____ **Postcode:** ______________

Home Phone: ___________________ **Mobile Phone:** _____________________ **Work:** ___________________

Email: ____

Custody Issues/Court Orders (if applicable)

If parents are separated or divorced: **Does the child have contact with both parents? Yes/No**
Is anyone legally denied access to the child? Yes/No

If there are court orders in place or any legal documentation relating to the custody of the children please provide a copy of this information with your enrolment.

Emergency Contacts (if parents are un-contactable)

Contact 1		
Name:	**Relationship to Child:**	
Address:		**Postcode:**
Home Phone:	**Work Phone:**	**Mobile Phone:**

Contact 2		
Name:	**Relationship to Child:**	
Address:		**Postcode:**
Home Phone:	**Work Phone:**	**Mobile Phone:**

NOTE: It is very important you tell these people that you have nominated them. In nominating them, you give them authority to act on your child's behalf if neither parent/guardian can be located to pick up the child in an emergency and care for the child until he/she can be returned home.

Other adults authorised to collect child:			
1	**Name:**	**Mobile:**	**Relationship to child:**
2	**Name:**	**Mobile:**	**Relationship to child:**

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

Medical Information

Child's Name:	**Type**	**Please Provide:**
Allergies: if your child is required to take medication in the case of an allergic reaction, please complete a Medical Management Plan (Additional forms required) **Yes** **No**		• **An Action Plan** • **A Risk Management Plan** • **Medical Conditions Communication Plan**
Disabilities: Does your child have physical limitations or a medical condition. Please provide details **Yes** **No**		• **An Action Plan** • **A Risk Management Plan** • **Medical Conditions Communication Plan**
Emotional/Behavioural Problems **Yes** **No**		• **An Action Plan** • **A Risk Management Plan** • **Medical Conditions Communication Plan**
Special Diet **Yes** **No**		• **An Action Plan** • **A Risk Management Plan** • **Medical Conditions Communication Plan**

Asthma and use of puffers – if your child is required to take medication in the case if an asthma attack, please complete an Asthma Risk Management Plan. (Additional forms required) **Yes No**		• **An Action Plan** • **A Risk Management Plan** • **Medical Conditions Communication Plan**
Medications – if your child is required to take medication at OSHC a Medical Management Plan is required before the enrolment can be processed. (Additional forms required – please see Director) **Yes No**		• **An Action Plan** • **A Risk Management Plan** • **Medical Conditions Communication Plan**
Other Medical **Yes No**		• **An Action Plan** • **A Risk Management Plan** • **Medical Conditions Communication Plan**
Cultural/Religious Requirements **Yes No**		
Immunisations up to date (including COVID vaccinations)? (Please supply a copy of Immunisation records) **Yes No**		• **A copy of immunisation records**

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 where necessary.

Medicare Number: ________________________ Health Care Card Number: __________________________

Private Health/Medical Benefits Cover with: _________________________ Ambulance Cover? Yes/No

We aim to provide inclusive quality care for a range of children from differing cultures and backgrounds. Please share with us a little of your family's background information so we can incorporate this within our program.

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Parent/Guardian Declaration

I understand that:

- I agree to pay the required fee for my child's booked OSHC/Vacation Care hours and accept the policies and rules of the service.
- Each child must be signed in and out each day on the Attendance Record.

If an illness or accident occurs, the parent/guardian will be contacted as soon as possible. However, in the event of my child requiring urgent medical treatment, I authorise the care providers and staff

- To obtain appropriate medical assistance and I agree to pay all medical and transport costs incurred on behalf of my child.

We endeavour to keep Gulfview Heights Primary School OSHC/Vacation Care a happy and safe environment for children. To do so we ask that children in our care adheres to our behavioural rules. Children who frequently exhibit unacceptable behaviour may be excluded from the program.

- The supervision and care of children is strictly limited to the hours care is provided. See handbook for operating hours.
- The OSHC/Vacation Care service must be notified if my child/ren are to be collected by someone that is not nominated on this form.
- Cancellation or changes to permanent/casual bookings require 24 hours' notice to be given.
- The OSHC/Vacation Care Service will refuse a child/ren access to the service if they have an outstanding account longer than 28 days.
- I will undertake to notify the service of any changes to details on this form.

I certify that all the information given on this form is true, accurate and correct. I further certify that I have read and agree to adhere to the policies and rules regarding Gulfview Heights Primary School OSHC/Vacation Care Service.

Print Name: ________________________________

Signature: __________________________________

Date: ______________________________________

Consents

	Please initial box
I consent for my child to take part in supervised walking excursions and visiting the local playground as part of the services After School Care program.	
I consent to my child to be photographed as part of the Out of School Hours Care program and to have them displayed around the service.	
I consent for OSHC staff to apply sunblock to my child if they require assistance.	
I consent for my child to watch PG-rated movies/videos/DVDs at the discretion of the Director.	
I consent for OSHC staff to ring for an ambulance for my child in the event of a medical emergency and parents/guardians will be contacted immediately.	
I consent for OSHC staff to administer simple first aid to my child if the need arises.	

Is there anything more we need to know?

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Booking Form

Please indicate your required OSHC bookings on the table below

Before School Care	Monday	Tuesday	Wednesday	Thursday	Friday
6.30am – 8.35am					
From _____ /_____ /______ Until _____ / ______ /______ Ongoing permanent bookings Yes/No					

After School Care	Monday	Tuesday	Wednesday	Thursday	Friday
3.10pm – 6.30pm					
From _____ /_____ /______ Until _____ / ______ /______ Ongoing permanent bookings Yes/No					

I have no regular times at this stage – I would like to use the service on a casual basis.
What date will your child commence? ____

Parent/Guardian

I agree to the terms and conditions of the above. Please sign below.
Print name: ____
Signature: ____
Date: ____

Office Use Only

1. CRN	
2. D.O.B	
3. Bookings	
4. Email address	
5. OSHC Medical Plans received	
Entered by:	
Date:	