



Enrolment Form - 2020

Child/ren's Full Name	Date of Birth	Gender	Grade	Centrelink CRN
1)	/ /	M / F		
2)	/ /	M / F		
3)	/ /	M / F		
4)	/ /	M / F		

Is your child/ren of Aboriginal (A) and/or Torres Strait Islander (TSI) Origin? Y / N – A TSI Both A/TSI

Child/ren's Address

Street				
Suburb		State		Postcode

Parent/Guardian 1

Parent/Guardian 2

Name				Name			
Address	<i>(If different from child/ren)</i>			Address	<i>(If different from child/ren)</i>		
Relationship to Child/ren				Relationship to Child/ren			
Date of Birth		Gender: M / F		Date of Birth		Gender: M / F	
Mobile No				Mobile No			
Home Ph No				Home Ph No			
Work Ph No				Work Ph No			
Occupation				Occupation			
Work Details	Company Name			Work Details	Company Name		
	Company Address				Company Address		
Parent/Guardian Authorised to collect children? Y / N				Parent/Guardian Authorised to collect children? Y / N			
Authorised as an emergency contact/pick-up? Y / N				Authorised as an emergency contact/pick-up? Y / N			
Authorised to consent to Medical Treatment? Y / N				Authorised to consent to Medical Treatment? Y / N			
Authorised to give permission for an Excursion? Y / N				Authorised to give permission for an Excursion? Y / N			

Parent/Guardian's name for Centrelink connection plus Customer Reference Number (CRN).

Name

CRN

Email addresses to receive accounts, service news and other important information.

Is a parent/guardian diagnosed with a disability? Y / N

Please indicate parent/guardian's name and disability.

Are there any family custody/court orders in place? Y / N

If **YES**, are they attached? Y / N

Please note – Permanent bookings will be accepted before casual bookings. A waiting list may occur.

Authorised Persons to collect Child/ren other than Primary Parent/Guardian

Please note these persons must have photo ID to pick up your child. Recommendation is for at least one authorised person to be listed.

Name		Name	
Address		Address	
Relationship to Child/ren		Relationship to Child/ren	
Mobile No		Mobile No	
Home Ph No		Home Ph No	
Emergency Contact	Y / N	Call Order (After Guardians)	e.g. 3rd
Emergency Contact	Y / N	Call Order (After Guardians)	e.g. 4th
Authorised to consent to Medical Treatment	Y / N	Authorised to give permission for an Excursion	Y / N
Authorised to consent to Medical Treatment	Y / N	Authorised to give permission for an Excursion	Y / N

Name		Name	
Address		Address	
Relationship to Child/ren		Relationship to Child/ren	
Mobile No		Mobile No	
Home Ph No		Home Ph No	
Emergency Contact	Y / N	Call Order (After Guardians)	e.g. 5 th
Emergency Contact	Y / N	Call Order (After Guardians)	e.g. 6 th
Authorised to consent to Medical Treatment	Y / N	Authorised to give permission for an Excursion	Y / N
Authorised to consent to Medical Treatment	Y / N	Authorised to give permission for an Excursion	Y / N

Medical Details

Doctor's Name		Phone	
Doctor's Address			
Dentist's Name		Phone	
Dentist's Address			
Medicare No	_____	Child's No on Card	Child 1 Child 2 Child 3 Child 4
Private Health Membership No		Private Health Fund Name	
Is your child/ren fully immunised? Y / N			
If NO , please tick which immunisations they have had?		<input type="checkbox"/> Pneumococcal Conjugate (13vPCV) <input type="checkbox"/> Rotavirus <input type="checkbox"/> Measles-Mumps-Rubella (MMR) <input type="checkbox"/> Meningococcal ACWY <input type="checkbox"/> Chickenpox (Varicella)	
<input type="checkbox"/> Hepatitis B (HepB) <input type="checkbox"/> Diphtheria-Tetanus-Whooping Cough (Pertussis) <input type="checkbox"/> Hib (Haemophilus Influenzae Type B) <input type="checkbox"/> Polio (Inactivated Poliomyelitis)			
Office use only - Has the Child/ren's health record been sighted by an authorised educator? Y / N			

Additional Medical Information, Needs and Considerations	
Please indicate if your child/ren is diagnosed to be at risk of anaphylaxis:	
Please write child's name and attach their Anaphylaxis Medical Management Plan: Please complete the following – Medical Conditions Risk Minimisation Plan and Communication Plan plus Authority Form to Administer Medication.	
Please indicate if your child/ren has any allergies: Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	
Please write child's name and attach their Allergy Medical Management Plan: Please complete the following – Medical Conditions Risk Minimisation Plan and Communication Plan plus Authority Form to Administer Medication.	
Please indicate if your child/ren has asthma: Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	
Please write child's name and attach their Asthma Medical Management Plan: Please complete the following – Medical Conditions Risk Minimisation Plan and Communication Plan plus Authority Form to Administer Medication.	
Please indicate if your child/ren has any medical condition/s or regular medication requirements:	
Please write child's name and note updated documentation from a doctor. Please complete the following – Medical Conditions Risk Minimisation Plan and Communication Plan plus Authority Form to Administer Medication.	
Please indicate if your child/ren has any special dietary needs:	
Please write child's name and suggest alternative foods to dairy, meat etc. if applicable:	
Please indicate if your child/ren has a diagnosed disability:	
Please write child's name and give details of the disability plus any assistance/needs/considerations the staff may need to apply:	
Please indicate if your child/ren has any behavioural, emotional, physical or other needs/considerations:	
Please write child's name and indicate their needs or considerations and how staff can assist:	
Please indicate your child/ren's cultural background. You may also wish to list the family's cultural background:	
Please write child's name and indicate their cultural background.	
Please indicate if your child/ren has any cultural or religious requirements that we can assist with:	
Please write child's name and indicate any special events they may celebrate or activities you would prefer they did not participate in:	
Is English your child/ren's first language? Y / N If NO , please complete the box below:	
Please write child's name and indicate any other languages spoken plus the level of English spoken:	
What language/s is spoken in the child's family home?	Language/s spoken:

Permissions	
I give permission for my child/ren's photograph to be used for display purposes at the service or included in newsletters etc. (These will not be made available outside the school and OSHC community unless a separate photo permission form is signed by a parent/guardian).	Y / N
I give permission for educators of Sherwood State School OSHC to obtain information from the school administration office/teacher in case of emergency, absences or to gain relevant information concerning my child/ren's wellbeing.	Y / N
I give permission for educators of Sherwood State School OSHC to observe or evaluate my child's participation in the program for developmental purposes and to plan activities.	Y / N
I give permission for sunscreen to be given to my child or applied by an educator (if needed) as per Sun Safety Policy. <i>Children cannot participate in outdoor play without sun protection.</i>	Y / N
All children from year 1 will depart at 8:30am in the morning to go to their classrooms. Preps will be escorted by an educator at 8:40am. Children may not leave OSHC prior to 8:30am unless they attend an extra-curricular activity or need to attend a special organised event.	Y / N

2020 (Updated) Sherwood State School OSHC Terms and Conditions

Emergency Medical Care Consent

1. I give consent to the service's Approved Provider, Nominated Supervisor or educator to seek medical treatment for my child from a registered medical practitioner, hospital or ambulance service, including the transportation of my child via ambulance.
2. I agree the cost of any emergency medical treatment or transport provided by a registered medical practitioner for my child's treatment will belong to myself (the parent, account holder or authorised person).
3. I give consent for a suitably qualified and trained educator to administer first aid, as required, to my child(ren).

Changes of Details

4. I will inform Sherwood State School OSHC of any changes to my child(ren)'s details or information outlined in the enrolment form, including custody agreements, parenting plans, or court orders that limit contact or access by any person to my child.

Information Handling and Confidentiality

5. I acknowledge information collected and held by the service is not divulged or communicated to another person other than -
 - a. to the extent necessary for the education and care or medical treatment of the child whom the information relates;
 - b. a parent of the child for whom the information relates;
 - c. the Regulatory Authority or Authorised Officer;
 - d. as expressly authorised, permitted or required to by law; or
 - e. with the written consent from the person who provided the information.
6. All personal information collected by the service is only used in the provision of education and care and as required by statutory obligation. Employees and personnel are guided by the services Information Handling (Privacy and Confidentiality) Policy (10.8).

Arrival and Departures

7. I understand children are to be signed into Before School Care or Vacation Care by a parent, caregiver or suitable authorised person.
8. I understand children are only permitted to leave the service in a manner consistent with the *Education and Care Service National Regulations*. I acknowledge, apart from the exception of an emergency, I must provide written consent for my child to be collected by any persons not already specified in the enrolment form.

Infectious Disease Control

9. I agree to immediately notify the service of any occurrence of infectious disease my child(ren) has either received a diagnosis or is suspected to be a cause of their illness, where people attending the service have potentially been exposed.
10. I acknowledge that I must keep my child(ren) from attending the service if they are at risk of spreading an infectious disease.
11. I recognise the service's exclusion periods will be guided by the National Health and Medical Research Council and the service will refuse my child's attendance until this relevant period has been served or under the written advice of a registered medical practitioner.
12. I agree that my child will be excluded from the service where there is an outbreak of an infectious disease against which they have not been immunised. The period of exclusion will be in accordance with the National Health and Medical Research Council's recommendations.

Absences

13. I agree to inform Sherwood State School OSHC of any absences where my child(ren) will not attend a session of care they have been booked for.
14. I acknowledge where I have failed to provide sufficient notice, as outlined in the service's policies I will be charged the full fee for the session.

Accounts and Fees

15. I understand my child's placement, and the ongoing booking of care is conditional on the payment of account fees.
16. I understand the service's fee policy is accessible by parents and is located in the OSHC office.
17. I understand that I must provide all necessary information (including CRN and birth date) to the service to receive Child Care Subsidy (CCS). I also acknowledging it is the caregiver's responsibility to link their child(ren) to the service through Centrelink.

Conduct

18. I acknowledge I have received a copy of the Sherwood State School OSHC Family Handbook and agree to follow the expectations contained within it.
19. I will follow any relevant code of conduct to uphold the service's commitment to quality education and care, child safety, and promoting healthy wellbeing.

Parent/Guardian's Confirmation:

Full Name: _____ Signature: _____ Date: _____

Full Name: _____ Signature: _____ Date: _____

Office use only:

Account Name: _____ Enrolment Fee Paid: <input type="checkbox"/> Debitsuccess Details Returned: <input type="checkbox"/> F/N-A F/N-B Term Date received: / / Date entered: / / Details entered by: _____	DOB's and CRN's completed <input type="checkbox"/> Personal Details <input type="checkbox"/> Medical Information, Needs and Considerations <input type="checkbox"/> Permissions <input type="checkbox"/> Photos <input type="checkbox"/> Sunscreen <input type="checkbox"/>
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Enrolment Form received: Date: _____ Time: _____ am/pm