

SACRED HEART AFTER SCHOOL & BEFORE SCHOOL CARE ENROLMENT FORM 2020

ABN 26 142 832 285

For bookings, cancellation or enquiries

Contact Debbie Worm on

Ph 03 5824 1841

9.00am to 4.00pm Monday to Friday

Before & After School Care Contact

Contact Tracy Marshall on

Mobile 0400 649 379

7:30am to 8:30am & 3pm to 6pm Monday to Friday

Email: dworm@shtatura.catholic.edu.au

tmarshall@shtatura.catholic.edu.au

Family Assistance CRN Numbers: Family Office Provider CRN 407 212 726X Sponsor CRN 407 198 256H

DETAILS OF CHILD

First Name _____ Preferred First Name _____

Surname _____

Male _____ Female _____ (Please circle) Date of Birth _____

Address of child: _____

Language spoken _____ Cultural Background of Child _____

Main language spoken at home _____ Country of Birth: _____

Any special issues in relation to you child e.g. religion, food, etc?

Does your child have a disability? Yes No (please circle)

Name of Disability _____

School _____

Grade _____ Teacher _____

DETAILS OF PARENT/GUARDIAN No. 1 (Authorised Nominee)

First Name _____

Preferred First Name _____ D.O.B / /

Surname _____

Address _____

Telephone (Home) _____ (Work) _____

(Mobile) _____

Employer _____ Occupation _____

Language spoken at home _____

Does the child live with this parent/guardian? Yes No (please circle)

DETAILS OF PARENT/GUARDIAN No. 2

First Name _____

Preferred First Name _____ D.O.B / /

Surname _____

Address _____

Telephone (Home) _____ (Work) _____

(Mobile) _____

Employer _____ Occupation _____

Language spoken at home _____

Does the child live with this parent/guardian? Yes No (please circle)

OTHER RESIDENCY ARRANGEMENTS

(Please give details)

Telephone (Home) _____

Name _____ (Work) _____

(Mobile) _____

EMAIL INFORMATION: ASC information will sent electronically.

Email: _____

PERSONS AUTHORISED TO COLLECT CHILDREN

Name _____ Relationship to child _____

Address _____

Phone Numbers (Work) _____ (Home) _____

(Mobile) _____

Name _____ Relationship to child _____

Address _____

Phone Numbers (Work) _____ (Home) _____

(Mobile) _____

Name _____ Relationship to child _____

Address _____

Phone Numbers (Work) _____ (Home) _____

(Mobile) _____

Name _____ Relationship to child _____

Address _____

Phone Numbers (Work) _____ (Home) _____

(Mobile) _____

EMERGENCY CONTACTS (Maximum 30 minutes from the service)

In case of emergency or injury, trauma or illness when parent/guardians are not available please state two people who could pick up the child and take care of them for the day and authorise consent to give medication by the child carer. In the event that the child is not collected from the children's service and the parent or guardians cannot be contacted, this list will also be used to arrange someone to collect the child.

Name _____ Relationship to child _____

Address _____

Phone Numbers (Work) _____ (Home) _____

(Mobile) _____

Name _____ Relationship to child _____

Address _____

Phone Numbers (Work) _____ (Home) _____

(Mobile) _____

ACCOUNT DETAILS

Invoice to be sent to:

Parent/Guardian 1 Or Parent/Guardian 2 (Please circle)

FEES

Have you applied for Child Care Benefits? YES NO (Please circle)

(If yes, please provide relevant information)

(CRN = Customer Reference Number for Child Care Benefit)

Parent/Guardian CRN _____ Date of Birth _____

Parent/Guardian CRN _____ Date of Birth _____

Child CRN _____

TICK THE DAYS YOUR CHILD WILL BE ATTENDING THE SERVICE

 AFTER SCHOOL CARE PERMANENT BOOKING (Please circle)
Monday Tuesday Wednesday Thursday Friday

 BEFORE SCHOOL CARE PERMANENT BOOKING (Please circle)
Monday Tuesday Wednesday Thursday Friday

CASUAL/EMERGENCY CARE

Please tick if you will require casual care only

CUSTODY DETAILS

Are there any special access/custody arrangements? YES NO (please circle)

If yes, please give details _____

If a court order exists please provide this information to the co Coordinator.

1. Bring the original court order/s for staff to see and a copy to attach to the enrolment form.

If these orders;

Change the power of a parent/guardian to:

Authorise the taking of the child outside the service by a staff member of the service.

Consent to the medical treatment of the child

Request or permit the administration of medication to the child

Collect the child.

AND/OR

Give these powers to someone else,

Please describe these changes and provide the contact details of any given powers:

MEDICAL INFORMATION

How would you describe your child's health? _____

Is he/she under any medical treatment? Please circle Yes No

Please give details _____

Has he/she had any history of illness? Please give details _____

Allergies _____

Medical conditions _____

Medical Plan _____

Other _____

Asthma YES NO (please circle)

Do you have an Asthma plan? YES NO (please circle) If yes please supply a copy.

Are there any known triggers? _____

Has your child been immunised? YES NO (please circle)

Name of person/s authorized to consent to the medical treatment of the child: _____

FAMILY DOCTOR

Doctor's Name _____ Phone _____

Name of Practice _____

Address _____

Medicare Number _____

Do you have private health insurance? YES NO (Please circle)

If yes Fund name _____ Fund Number _____

Do you subscribe to an ambulance service YES NO (please circle)

If yes, please state the Ambulance Subscription Number: _____

OTHER INFORMATION

Is there any other information we should know about your child? YES NO (please circle)

Likes, dislikes, fears, cultural information etc. _____

What are your child's current interests? _____

Is there anything you would like your child to develop at ASC? _____

Do you have any concerns? _____

DECLARATION AND CONSENT TO EMERGENCY MEDICAL TREATMENT

I/We _____ (Print full Name)

Person/s with lawful authority of the child referred to in this enrolment form,

Declare that the information in this enrolment form is true and correct and undertake to immediately inform the OSHC service in the event of any change to this information.

Agree to collect or make arrangement for the collection of the child referred to in this enrolment form if he/she becomes unwell at the service.

Consent to the staff of the OSHC service seeking medical treatment by a medical practitioner, hospital or ambulance, or where appropriate, administer such emergency medical treatment as is necessary and agree to reimburse any necessary expenses incurred by the OSHC service.

Undertake to inform the staff of any absences of my child from the service.

Accept full responsibility for my child's belongings whilst attending the service.

If I am the last parent/adult I shall wait with staff member until lock up has been completed for security for a OSHC single staff model service.

Signature _____

Signature _____

PHOTOGRAPHIC CONSENT

I give permission for my child to be photographed by staff members; I understand that these photos are for the service use only and may be used for promotional materials for the service.

YES NO (please circle)

SUNSCREEN CONSENT

I give permission for my child to have 30+ sunscreen applied as per the service's Sun Smart Policy.

YES NO (please circle)

POLICY AND PHILOSOPHY STATEMENT

I agree to abide by all policy and philosophy guidelines of the service.

YES NO (please circle)

PARENT/GUARDIAN SIGNATURE _____ Date: ___/___/___

PARENT/GUARDIAN SIGNATURE _____ Date: ___/___/___

PRIVACY NOTIFICATION

The Sacred Heart After School Care uses the enrolment form to collect personal information for the purpose of the service enrolment and statistical recording. The information may be shared with funding agencies and administrators for operational purpose 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.