SACRED HEART AFTER SCHOOL & BEFORE SCHOOL CARE ENROLMENT FORM 2021

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
Email: dworm@shtatura.catholic.edu.au

Before & **After School Care Contact**
Contact Tracy Marshall on
Mobile 0400 649 379
7am to 8:30am & 3pm to 6pm Monday to Friday
asc@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. 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 if 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 you 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, lease 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 you're your child's current interests? _____

_____

Is there anything yon 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 SIGNITURE_____ Date: ___/___/___

PARENT/GUARDIAN SIGNITURE _____ 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.