

St John's Outside School Hours Care Enrolment Form



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Where the term *Nominated Supervisor* is used, this refers to the person placed in the day-to-day charge of the service or their delegate. The *Diocese of Rockhampton Privacy Statement* can be found in the service's *Family Handbook*. This outlines the service's commitment to the confidentiality of records.

CHILD'S FULL NAME			
Name child is known by			
Child's Customer Reference No.			
Child's date of birth			
Child's age on commencement day		Child's Gender	
Child's address			
Country of birth			
Cultural background			
Does your child identify as:	Aboriginal Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> and/or Torres Strait Islander Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		
Primary Language Spoken			
Religion			
Commencement at service date			
End date			
Child's Medicare Number (if applicable)			
School Attending in year enrolled (including suburb)			
Year level/grade in year enrolled			
PARENT/CARER (Full Name)			
Customer Reference Number		Date of Birth	
Relation to Child			
Mobile Number			
Email Address			
Home Phone Number			
Address (include suburb & postcode)			
Work Phone Number			
Work Address			
Occupation			
Organisation/Employer			
Primary Language Spoken			
Cultural background		Nationality	
Religion			

PARENT/CARER (Full Name)			
Customer Reference Number		Date of Birth	
Relation to Child			
Mobile Number			
Email Address			
Home Phone Number			
Address (include suburb & postcode)			
Work Phone Number			
Work Address			
Occupation			
Organisation/Employer			
Primary Language Spoken			
Cultural background		Nationality	
Religion			

Please attach relevant Health Care Card &/or 'Care Arrangements' documentation (if applicable).

Are there any written arrangements?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Copy of original provided Yes <input type="checkbox"/> No <input type="checkbox"/> (N.B.original documents must be sighted by Nominated Supervisor)
Are there any court orders affecting the child?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Copy Provided Yes <input type="checkbox"/> No <input type="checkbox"/> (N.B.original documents must be sighted by Nominated Supervisor)
Is there anyone legally denied access to the child?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Copy Provided Yes <input type="checkbox"/> No <input type="checkbox"/> (N.B.original documents must be sighted by Nominated Supervisor)
The following people are <u>NOT</u> authorised to collect my child:	
1. _____	2. _____

AUTHORISATION TO COLLECT/ EMERGENCY CONTACTS (Other than those already listed)

Persons authorised to collect child must be an adult. Alternatively, written authorisation must be provided for a person less than 18 years prior to that person collecting the child. Attach additional contacts as required.

Full Name:	Emergency Contact Signature:
Address:	
Contact Number/s:	Relationship to Child:
Full Name:	Emergency Contact Signature:
Address:	
Contact Number/s:	Relationship to Child:
Full Name:	Emergency Contact Signature:
Address:	
Contact Number/s:	Relationship to Child:

PERSON TO RECEIVE ACCOUNTS

Complete this section ONLY if the account is to be sent to only one of the parents/guardians/carers listed above.

Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Mr <input type="checkbox"/> Rev <input type="checkbox"/> Dr <input type="checkbox"/> Other <input type="checkbox"/>	
Given Name/s:	
Surname:	
Postal Address:	
City:	
State:	Post Code:
Relationship to child:	
I confirm that I am responsible for payment of fees and all associated costs.	
Signature:	

MEDICAL INFORMATION

Indicate if your child has been affected by or suffers from any of the following? *(Please circle Yes or No)*

Prenatal concerns	Yes / No	Asthma	Yes / No	Stomach complaints	Yes / No
Birth concerns	Yes / No	Headaches	Yes / No	Very high temperatures	Yes / No
Postnatal concerns	Yes / No	Head injury	Yes / No	Glandular fever	Yes / No
Vision concerns	Yes / No	Frequent colds	Yes / No	Ross River Virus	Yes / No
Hearing concerns	Yes / No	Ear infections	Yes / No	Rheumatic fever	Yes / No
Speech concerns	Yes / No	Epilepsy	Yes / No	Anorexia nervosa	Yes / No
Allergies	Yes / No	Diabetes	Yes / No	Bulimia	Yes / No
Anaphylaxis	Yes / No	Specific learning difficulty	Yes / No	Other (state below)	Yes / No
Knocked unconscious	Yes / No	Mental Health Issues	Yes / No		
If Yes to any of the above please provide necessary medical information: <i>(Attach a separate sheet if necessary)</i>					

List any medical alerts, diseases, surgery or disorders, or recurring illnesses:

Does the child suffer from any significant allergy? No Yes If Yes – please specify:

Does your child require an individual health or action plan for their medical condition? No Yes

(If yes, then the family and service must negotiate what is practicable. The individual action plan must be signed by an authorized medical practitioner).

Is the child taking any medication regularly? No Yes If Yes – please specify, and request the *Medication Consent Form* at interview. All medication is to be supplied by the family.

Any other medical information of which the service should be aware:

Does your child have any dietary requirements?

MEDICAL CONTACT DETAILS

Child's Doctor:	Phone Number:
Address:	
Child's Dentist:	Phone Number:
Address:	
Pediatrician	Phone Number:
Address:	

IMMUNISATION STATUS

Is your child fully immunised? Yes No

If **YES**, please provide a copy of your child's current immunisation record.

If you are a conscientious objector to immunisation, please provide a signed 'conscientious objector form' or letter notifying us of your child's status. This is not mandatory.

ADDITIONAL INFORMATION

To support your child at our service we welcome any further information you can provide:

Does your family observe any particular religious or cultural practices (including special celebrations/ traditions) that are significant to your child?

Does your child have any identified needs or is there additional information we require to support your child in a smooth transition into the service?

Has your child attended any specialist agencies? (e.g. speech pathologist, occupational therapist, audiologist, optometrist, psychologist etc.). Please supply any supporting documentation to assist the service in supporting your child.

We welcome family involvement. Please indicate if you would like to contribute to our program and in what way you would like to be involved:

CHILDCARE BENEFIT AND REBATE INFORMATION

This service is required to register all children enrolled and attending care, in the DEEWR Child Care Management System (CCMS). This is the system for processing Child Care Benefit and Child Care Rebate claims to ensure parents/carers receive reduced fees as well as, if eligible calculating and lodging information for the payment of the 50% Tax Rebate.

Under this system the parent/carer and child CRN (Customer Reference Number) and DOB (date of birth) are the dual validators to enable reduced fees to be charged.

It is essential that the information below precisely matches that submitted to Centrelink. Any discrepancies will lead to the outside school hours care service being unable to process the CCB & CCR claim and ensure the appropriate reduction in your fees.

Where parents/carers hold separate CRN's, a separate form for each parent will need to be completed. To ensure that you are able to take advantage of the reduction in fees under CCMS, please complete the section below following information and return to the St John's Outside School Hours Care service.

MULTIPLE CHILD PERCENTAGE

Do you have other children who will be attending an approved service **other** than this service?

Yes No Number of Children in Care

PLEASE COMPLETE OPTION ONE OR TWO:

Option 1:

Parent/Carer Full Name			
Parent/ Carer DOB: ___/___/___	Parent/Carer CRN:		
Child 1 (Full Name):	Eligible Hours for this service:	<input type="checkbox"/> 24 <input type="checkbox"/> 50 <input type="checkbox"/> Other - <input type="checkbox"/> No of Hours	
Child DOB: ___/___/___	Child CRN:		
Child 2 (Full Name):	Eligible Hours for this service:	<input type="checkbox"/> 24 <input type="checkbox"/> 50 <input type="checkbox"/> Other - No of Hours:	
Child DOB: ___/___/___	Child CRN:		
Child 3 (Full Name):	Eligible Hours for this service:	<input type="checkbox"/> 24 <input type="checkbox"/> 50 <input type="checkbox"/> Other - No of Hours:	
Child DOB: ___/___/___	Child CRN:		
Child 4 (Full Name):	Eligible Hours for this service:	<input type="checkbox"/> 24 <input type="checkbox"/> 50 <input type="checkbox"/> Other - No of Hours:	
Child DOB: ___/___/___	Child CRN:		
Signature:	Date: ___/___/___		

Option 2

I **do not** wish to provide the above information. I understand that I must therefore pay **full fees** for care received by my child/children at the St John's Outside School Hours Care service.

Parent Signature:	Date: ___/___/___
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REQUESTED DAYS OF ATTENDANCE

Permanent Booking or Casual Booking

I/we hereby agree to the days indicated below for my child to attend St John's Outside School Hours Care for the period from ___/___/___ to ___/___/___.

CHILD'S NAME	MON	TUES	WED	THURS	FRI
	ASC	ASC	ASC	ASC	ASC

CONSENT STATEMENT

Where the term *Nominated Supervisor* is used, this refers to the person placed in the day-to-day charge of the service or their delegate. If you require assistance in reading or interpreting any of these consent statements, please discuss this with your Nominated Supervisor or delegate. The *Diocese of Rockhampton Privacy Statement* can be found in the service's *Family Handbook*. This outlines the service's commitment to the confidentiality of records.



Please tick the appropriate boxes where required.

AUTHORISATION TO OBTAIN MEDICAL ATTENTION

- On enrolling my/our child I/we understand that the service is unable to care for children who are sick or who have a contagious illness. I/we agree to keep my/our child at home while they are suffering from any infectious or contagious illness. I/we agree to collect my/our child if he/she is unwell. I/we further acknowledge that a medical clearance may be necessary before my/our child is able to return in accordance with *Queensland Health* guidelines.
- In the event of an emergency, illness or accident (when unable to contact parent/ carer or authorised persons) I/we consent to my/our child being transported by ambulance to obtain medical or hospital attention. I/we agree to pay any expenses incurred for medical treatment and transport.
- I further authorise a qualified medical practitioner to administer anaesthetic, blood transfusions, and perform surgical operations if the emergency requires such treatment.
- I/we authorize the use of life-saving medication, by qualified personnel on my/our child in an emergency situation.

CONDITIONS FOR MEDICATION TO BE ADMINISTERED

- I/we understand prescribed medication will only be administered when it is accompanied by written instructions from child's medical practitioner and/ or pharmacist and the service's *Authority to Administer Medication Form* is completed. All families are to supply medication for their child.
- I/we understand non-prescribed medications taken orally will only be given when they are in their original package with a pharmacist's label which clearly states the child's name, dosage, frequency of administration, date of dispensing and expiry date.
- I/we agree to advise in writing of the dose, time and date of the last dose of any medication given to my/our child so as to reduce the risk of overdosing.

HEALTH AND SAFETY PERMISSION

- I/we agree to provide alternative care arrangements when my/our child is suffering from an infectious or contagious illness as described by the exclusion guidelines in the *Family Handbook* or child is generally unwell and/or deemed unable to cope in a group setting by staff.
- I/we give permission for first aid qualified staff to administer first aid and/or medication to my/our child as required.
- I/we give permission for staff to apply adhesive bandages e.g. band aids to my child.
- I/we give permission for my/our child to participate in face painting activities.
- I/we give permission for my/our child to have 30+ sunscreen applied as required.
- I/we give permission for my/our child to have insect repellent applied as required.

ACTIVITIES PERMISSION

- I/we give permission for my/our child to participate in all activities offered by the service.
- I/we understand it is my/our responsibility to familiarise myself/ourselves with all aspects of the displayed program and to advise the service in writing if I/we do not wish for my/our child to participate in a particular activity.
- I/we give permission for my/our child to access the associated school's facilities during the session.
- I/we give permission for my/our child to view PG rated programs and games whilst at the service.

MEDIA PERMISSION

I/we give permission for internal displays at the service of (please tick the relevant boxes):

- Photographs
- Videos

Images may also be used for:

- External Displays e.g. Schools/ Catholic Education – Diocese of Rockhampton Office and events
- Service Newsletter
- Promotional material
- Website
- Publicity
- Images of my child that appear in group photos and the first name of my child that is written in internal documentation.

DELIVERY & COLLECTION

- I/we will ensure that my/our child is taken from the service by an authorized adult (18+ years) unless prior arrangements have been made with the Nominated Supervisor or delegate.
- I/we will ensure that our child is signed in/out of the service as per legislative requirements (approval for educator is given to sign in my child for After School Care).
- I/we acknowledge that the service will not accept any responsibility unless a parent/carers or authorised person signs in my/our child to the session (this may be an educator in the case of After School Care).

- I/we understand that I/we must **notify in writing** if a person, who is not authorised to collect my child, will be collecting my/our child from any session.
- I/we understand that if my /our child is not collected from the service by closing time that I/we may incur a late fee penalty as specified in the Fee Schedule.

FUNDING AGREEMENTS

- I/we understand that as the service is a not-for-profit organisation and that all fees received go directly into the operation of the service.
- I/we agree to pay all fees associated with the care of my/our child as per the *Fee Collection/Payment Procedure*, as I/we understand that the service relies on these funds to remain viable.
- I/we agree to pay fees within two weeks of receiving the invoice or as negotiated with the Nominated Supervisor e.g. direct debit fortnightly payments.

POLICIES, PROCEDURES & LEGISLATION

- To support my child further whilst at the service, I/we give permission for the Nominated Supervisor or representative to liaise with specialist staff or Catholic Education – Diocese of Rockhampton support personnel.
- I/we understand that our family’s contributions, culture, traditions and religious beliefs will be respected and where possible, included in the activities of the service.
- I/we understand that as the service is part of the Catholic Education – Diocese of Rockhampton.
- I/we will respect the Catholic ethos of the service.
- I/we understand that the service will embed the Catholic tradition into its program and my/our child will be encouraged to participate.
- I/we agree to abide by the service’s policies and procedures and to comply with all regulations and laws associated with the service.
- I/we the undersigned, state that I/we have read the *Family Handbook* and acknowledge the service will align to the mission, vision and values of Catholic Education – Diocese of Rockhampton.
- I/we agree to the *Priority of Access Guidelines* as set out in the *Enrolment & Booking Procedure*.
- I/we understand that it is my/our responsibility to ensure all information associated with my/our child’s enrolment is current and notify the service of any changes to details provided.
- I/we agree to conditions outlined in the service’s *Fee Collection/Payment* and *Enrolment & Booking Procedures*.
- I/we agree, to secure a position at the service, I/we must pay an enrolment fee. I/we agree that fees incurred will be paid in advance as per the *Enrolment & Booking Procedures*.
- I/we have read the *Promoting Wellbeing & Positive Relationships Parent Information Fact Sheet* and should unacceptable behaviour be displayed by my/our child agree that the procedure will be followed.
- I/we understand that I/we are financially responsible for any wilful damage of equipment or property by my child.
- I/we understand that information on this enrolment form may be provided upon request to either parent/carer detailed above or as identified on the child’s birth certificate (unless supported by a Court Order or other recognised legal document indicating otherwise).
- I/we have nominated an email address, and understand that account statements, newsletters etc. may be sent via email.

BOOKINGS

- I/we have completed the booking section nominating days of attendance required for my child.
- I/we understand that the request for attendance of additional days does not necessarily mean that a place will be available for my child.
- I/we agree to give the prescribed notice periods that are required for any cancellations.
- I/we understand that it is my responsibility to notify the services of any changes to booking details via the completion of a *Change to OSHC Days – Booking Form*.
- I/we acknowledge that full fees will be charged when my child is absent from a session for which they are permanently booked.

DECLARATION:

- I have read and understood the conditions of this contract and agree to abide by the contract.
- I certify that the information contained in this Enrolment Form is correct and agree to notify the person in charge of the service of any change to any information contained therein.

Parent/Carer Signature: _____ Date: __/__/__

Parent/Carer Signature: _____ Date: __/__/__

OFFICE USE ONLY

Date Received: _____ Date Entered: _____ By Whom: _____

Health Record Sighted (staff signature): _____

CCMS Enrolment Advance Claim BSC ASC VAC Date Claimed: _____ Total Amount Claimed \$ _____

Enrolment Fee Paid: N/A Yes \$ _____ No Holding Fee Paid: N/A Yes \$ _____ No

Original Enrolment form held at (service name and suburb): _____

Orientation Completed: Yes No Date _____

Comments/ additional documentation attached as required e.g.

- Copy of Birth Certificate
- Immunisation Record
- Copy of CRN
- Baptism Certificate
- Visa Documentation
- Copies of Court Orders Family Agreements etc.
- Medical Plans by Medical Practitioner (signed by medical practitioner and parent – for display in viewable area)
- Specialist information e.g. from Early Intervention Centre; Speech Pathologist