



CHILD'S DETAILS:

Child's First Name:	Child's Surname:	Preferred Name:
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:/...../.....	*Child's Centrelink CRN:
Address (No. and Street):	Suburb / Town:	Postcode:
Does this child identify as Aboriginal? <input type="checkbox"/> Yes _____ <input type="checkbox"/> No	Does this child identify as Zenadth Kes? (Formerly known as TS Islander) <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Language: Any Other Languages Spoken:
Are you claiming Childcare Benefits at another approved Childcare Service or services for this child? This includes LDC, OSHC, FDC, IHC, OCC <input type="checkbox"/> Yes – site name: _____ <input type="checkbox"/> No		
Details of Parental Custody / Court Orders relating to this child: Documentation attached: <input type="checkbox"/> Yes <input type="checkbox"/> No		

ENROLLING PARENT / GUARDIAN & BILLING DETAILS:

Full Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:/...../.....
Relationship to Child:	Contact Priority:	Primary Language: Any Other Languages Spoken:
Address (No. and Street):	Suburb / Town:	Postcode:
Phone (H):	Phone (W):	Mobile:
Email:	*Parent Centrelink CRN:	

***The Child's & Parent's CRN number must be provided in order to process enrolment & claim CCS**

OTHER PARENT / GUARDIAN (IF APPLICABLE):

Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:/...../.....
Relationship to Child:	Contact Priority: (High, Standard, Low):	Primary Language: Any Other Languages Spoken:
Address (No. and Street):	Suburb / Town:	Postcode:
Phone (H):	Phone (W):	Mobile:

Administration Use Only

Date Received: ___ / ___ / ____ Staff Member: _____ Received Notes: _____			
ENROLMENT FORMS: DD FORM: <input type="checkbox"/> Yes <input type="checkbox"/> N/A	CWA (Booking) Form: <input type="checkbox"/> Yes	Custody / Court Order Received: <input type="checkbox"/> Yes <input type="checkbox"/> N/A	
MEDICAL DOCUMENTATION / REQUIRED FORMS:	Health Care Plan/s: <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Risk Minimisation Form: <input type="checkbox"/> Yes <input type="checkbox"/> N/A	
Communication Plan: <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Permission to Administer Medication: <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Medication Authority Form: <input type="checkbox"/> Yes <input type="checkbox"/> N/A	
Medication Supplied (Correctly): <input type="checkbox"/> Yes <input type="checkbox"/> N/A	ISS Documentation Received: <input type="checkbox"/> Yes <input type="checkbox"/> N/A	ISS Form: <input type="checkbox"/> Yes <input type="checkbox"/> N/A	
INPUT:	Enrolment in System: <input type="checkbox"/>	CWA (Bookings) Input: <input type="checkbox"/>	Permissions Registered: <input type="checkbox"/>
	Medical Policy Provided to Family: <input type="checkbox"/>	Medication Bag Created: <input type="checkbox"/>	Kitchen Allergy Display: <input type="checkbox"/>
	Medical First Aid Cupboard Display: <input type="checkbox"/>	Input Dates of Forms: <input type="checkbox"/>	Input Dates of Medication: <input type="checkbox"/>
File DD Form: <input type="checkbox"/>	Added to ISS Display: <input type="checkbox"/>	Added to ISS Register: <input type="checkbox"/>	Name *RM / *K if required: <input type="checkbox"/>
			C/CO Noteworthy Display: <input type="checkbox"/>
			Medical Documents in Folder: <input type="checkbox"/>
			Team informed Information: <input type="checkbox"/>
			Activity Programmed: <input type="checkbox"/>
Date Input: ___ / ___ / ____ Staff Member: _____ Input Notes: _____ Emailed Account App Link: <input type="checkbox"/>			

EMERGENCY CONTACTS & COLLECTION AUTHORITIES:

You may nominate the following people to give them authority to be contacted in an emergency and be added to sign the child in/out of the service. These people must be over 18 Years old.

Full Name:	Contact Priority: (High, Standard, Low):	Relationship to Child:
Address (No. and Street):	Suburb / Town:	Postcode:
Mobile: Phone (H/W):	I nominate this person for the following (please circle): Emergency Contact (to be contacted in an emergency): YES NO Collection Authority (to pickup/drop off to the service): YES NO	
Full Name:	Contact Priority: (High, Standard, Low):	Relationship to Child:
Address (No. and Street):	Suburb / Town:	Postcode:
Mobile: Phone (H/W):	I nominate this person for the following (please circle): Emergency Contact (to be contacted in an emergency): YES NO Collection Authority (to pickup/drop off to the service): YES NO	

COLLECTION AUTHORITY FOR PRESCHOOLERS ATTENDING SFX OSHC & WYNN VALE COMMUNITY HOUSE KINDERGARTEN

By signing below I am giving Collection Authority to St Francis Xavier Regional Catholic School OSHC (SFX OSHC) & Wynn Vale Community House Kindergarten (to pickup and drop off to the services) as per the child's OSHC bookings and Preschool sessions.

Parent / Guardian signature:

By signing below I am giving Discussion Authority to St Francis Xavier Regional Catholic School OSHC (SFX OSHC) & Wynn Vale Community House Kindergarten (to discuss between the services) my child and their day, learning, observations and needs.

Parent / Guardian signature:

IMMUNISATION INFORMATION:

Has your child received all Immunizations scheduled for his/her age? <input type="checkbox"/> Yes <input type="checkbox"/> No if NO please provide details:	Has your child received the following Immunizations? (Please tick if yes) <input type="checkbox"/> (10 – 13 Years) Hepatitis B <input type="checkbox"/> (10 – 13 Years) Varicella (Chickenpox) <input type="checkbox"/> (12-18 Years) Human Papillomavirus (HPV)
If NO, I accept full responsibility for not Immunizing my child: Parent / Guardian signature:	

MEDICAL & HEALTH: INFORMATION & DOCUMENTATION

Does your child have any medical conditions ? If YES, please provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
All required Medical Documentation attached? (See below for required documentation) Please note if your child has a Medical Condition they cannot commence care until all required forms have been submit to OSHC.	<input type="checkbox"/> Yes
Does your child have any allergies ? If YES, please provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
All required Medical Documentation attached? (See below for required documentation) Please note if your child has a Medical Condition they cannot commence care until all required forms have been submit to OSHC.	<input type="checkbox"/> Yes
Does your child have any additional needs / diagnosis ? If YES, please provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
All required Medical Documentation attached? (See below for required documentation) SFX OSHC is an inclusion aware service. Please speak with the Director to complete an ISS form where the service can apply for additional support for your child in the environment. Please note if your child has a Medical Condition they cannot commence care until all required forms have been submit to OSHC.	<input type="checkbox"/> Yes

MEDICAL DOCUMENTATION REQUIRED: To meet Regulation 90 in the Education and Care National Regulations each child with a diagnosed health condition must have three plans in place: 1. **Medical management plan (also known as a health care plan)** 2. **Risk minimisation plan (or safety and risk management plan)** 3. **Communication plan (or health support agreement)**. If your child requires medication during their time at the service, you will also need to complete a **Permission to Administer Medication Form** and **sign the medication records**. Please **supply the service with any required medications in the original packaging with a pharmacy label stating your child's name and medication dosage**. Please ensure we always have up-to-date Medical Documentation for your child. See Director for further information and copies of forms and the Medical Policy. Email oshc@sfx.catholic.edu.au
I will provide SFX OSHC with all required medical documentation for my child. I will abide by SFX OSHC's medical policy & procedures. I understand failure to do so will result in my account being suspended.
Parent / Guardian signature:

Does your child have any conditions / is using medications that might be effected by OSHC activities? If YES, please provide details such as any related treatment / conditions / medication or information:	<input type="checkbox"/> Yes <input type="checkbox"/> No
---	--

Does your child have any special dietary requirements not related to allergies? If YES, please provide details:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your child suffer from any illnesses that may re-occur (eg: chronic ear infection)? If YES, please provide details such as any related treatment / conditions / medication or information:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your child have any special aids (eg: glasses, hearing aids, sensory tools etc)? If YES, please provide details:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there any other information we might need to know about your child? If YES, please provide details:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Doctor / Medical Centre Name, Address and Contact Details. Doctor: _____ Centre: _____ Address: _____ Phone No: _____	Dentist Name, Address and Contact Details. Dentist: _____ Centre: _____ Address: _____ Phone No: _____	
Private Medical Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No Fund: _____	Medicare Number: Child's Reference No. on Card:	
Ambulance Cover: <input type="checkbox"/> Yes <input type="checkbox"/> No Fund: _____	Health Care Card Number:	

CULTURAL BACKGROUND:

Cultural background of child / family:	Religion:
Does your child have any cultural needs you would like to inform the service of? If YES, please provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there anything that your child cannot eat or participate in due to cultural background or religious beliefs? If YES, please provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any cultural traditions that your child / family observe that you would like to inform the service of? If YES, please provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No

CONSENTS:

I/We consent to my child being photographed for the purpose of observations and documentation of programmed activities at OSHC.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I/We consent to my child's photo being used in observations – individual and group (eg. sending photos and observations through the app about your child's time at OSHC ect)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I/We consent to my child having sunscreen applied.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I/We consent to my child participating in general sports and physical activities.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I/We consent to my child watching a PG rated movie or show in the event that one has been deemed appropriate to watch by OSHC educators. Most movies / shows that will be put on are G.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I/We consent to my child playing the Nintendo Switch. Games are rated G – apart from some PG rated games deemed appropriate by OSHC Management (such as Minecraft & Lego)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I/We consent to the Director using the email address provided on this form to send the account details/information.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I/We consent to OSHC staff administering First Aid to my child.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I/We consent to OSHC staff taking my child to a local hospital or medical centre if required in the event of an injury.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I/We consent to OSHC staff calling an ambulance in the event of a medical emergency if required.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ADDITIONAL INFORMATION:

Please provide any additional information you would like to make the service aware of. Attaching additional documentation: <input type="checkbox"/> Yes: _____	<input type="checkbox"/> No
---	-----------------------------

AGREEMENT:

I/We agree to comply with the policies and procedures at the service.

Yes

No

I/We agree to pay all required fees for the booked childcare hours in accordance with the OSHC Fees Policy.

Yes

No

I/We agree that it is my/our responsibility to ensure all Child Care Benefit requirements are fulfilled and if I/we fail to do so I/we will be responsible for paying the full childcare fees to the service.

Yes

No

I/We agree to cover all costs incurred for any external medical treatment my/our child receives in the event of an accident or injury sustained during an OSHC session. Then if eligible I can contact the Director of OSHC and the WHS Officer to discuss options regarding any out of pocket expenses incurred. (Assessed case by case)

Yes

No

I/We certify that the information provided in this enrolment form is true to the best of my knowledge and I undertake to inform the service if any details change.

Note: This Enrolment Form consists of four (4) pages; please ensure all pages have been completed before signing and any additional documents that may be required by the service have been provided.

Parent / Guardian (1) Signature: _____ Date: ____/____/____

Parent / Guardian (2 if applicable) Signature: _____ Date: ____/____/____

Getting to know your child

ENROLMENT SURVEY



CHILD NAME:

PARENT/ GUARDIAN NAME COMPLETING THIS FORM:

ANY SIBLINGS OR PETS?

WHAT ARE SOME OF YOUR CHILD'S STRENGTHS?

WHAT ACTIVITIES DOES YOUR CHILD ENJOY?

DOES YOUR CHILD KNOW SOMEONE THAT ALREADY ATTENDS OSHC?

WHAT DO YOU HOPE YOUR CHILD PARTICIPATES IN, LEARNS OR EXPERIENCES WHILST AT OSHC?

WHAT IS YOUR CHILD'S FAVOURITE HEALTHY SNACK?

WHAT ARE 3 WORDS YOU WOULD USE TO DESCRIBE YOUR CHILD?

DOES YOUR CHILD HAVE A FAVOURITE CHARACTER, MOVIE OR SHOW?

ANY SPECIAL FAMILY TRADITIONS?
