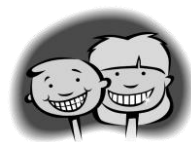


2017

Chilwell Primary School Outside School Hours Care REGISTRATION



Child/ren's Details:

SURNAME: _____ TELEPHONE: _____ MOBILE: _____

ADDRESS: _____ Post Code: _____

EMAIL: _____ ORIENTATION COMPLETED / /

Child/ren's Names	Date of Birth / Age / Sex	School	Grade	Teacher
1	/ / M / F			
2	/ / M / F			
3	/ / M / F			

Parent/Guardian Details:

Name:	Name:
Date of birth:	Date of birth:
Relationship to child:	Relationship to child:
Home address:	Home address:
Home phone:	Home phone:
Email:	Email:
Employer:	Employer:
Hours of employment:	Hours of employment:
Work Address:	Work Address:
Work phone:	Work phone:

Name:	Name:
Date of birth:	Date of birth:
Relationship to child:	Relationship to child:
Home address:	Home address:
Home phone:	Home phone:
Email:	Email:
Employer:	Employer:
Hours of employment:	Hours of employment:
Work Address:	Work Address:
Work phone:	Work phone:

The above child(ren) reside with (please tick appropriate box)

Both parents Mother Father Guardian

Custody Details: (Parenting Orders, Parenting Plans)

Are there special access/custody arrangements? YES / NO

If a court order exists please provide this information to the program staff.

Cultural Information:

Main language spoken at home: _____ Family Ethnic Origin: _____

Child Care Benefit (CCB)

CCB information is listed on the last page of the enrolment form please take the time to read it carefully and collect all the information we require. We must have CRN numbers for your child to attend care.

Would you like to claim these reduced fees as a session deduction or end of financial year lump sum?

Session reduced fee (preferred option)

End of financial year lump sum payment

Emergency Contacts/ Authorised persons allowed to take children out of service:

1. Name _____ Phone: _____
 Emergency Contact Yes / No _____ Address _____
 Authorised to authorise an educator to take children out of service Yes / No _____
 Authorised nominee Yes / No _____
 Authorised to consent medical treatment of, or to authorise administration of medication to each child Yes / No _____

2. Name _____ Phone: _____
 Emergency Contact Yes / No _____ Address _____
 Authorised to authorise an educator to take children out of service Yes / No _____
 Authorised nominee Yes / No _____
 Authorised to consent medical treatment of, or to authorise administration of medication to each child Yes / No _____

3. Name _____ Phone: _____
 Emergency Contact Yes / No _____ Address _____
 Authorised to authorise an educator to take children out of service Yes / No _____
 Authorised nominee Yes / No _____
 Authorised to consent medical treatment of, or to authorise administration of medication to each child Yes / No _____

Authorised Nominee - a person who has been given permission by a parent or family member to collect the child from the education and care service

Medical Details:

Doctor _____ Phone _____
 Address: _____
 Medicare Number _____ Ambulance Service Subscriber YES / NO _____

Health/Medical History. Please circle:

Child 1. Asthma / Allergies / Anaphylaxis / Epilepsy / Disability / ADD / ADHD (please circle)
 Other _____
 Plan Risk Minimisation Epipen Medical policy to parent
 Communication Difficulties: Hearing / Sight / Speech etc.
 Is child fully immunised? Yes / No _____ Record sighted. Yes / No Initials: _____

Child 2. Asthma / Allergies / Anaphylaxis / Epilepsy / Disability / ADD / ADHD (please circle)
 Other _____
 Plan Risk Minimisation Epipen Medical policy to parent
 Communication Difficulties: Hearing / Sight / Speech etc.
 Is child fully immunised? Yes / No _____ Record sighted. Yes / No Initials: _____

Child 3. Asthma / Allergies / Anaphylaxis / Epilepsy / Disability / ADD / ADHD (please circle)
 Other _____
 Plan Risk Minimisation Epipen Medical policy to parent
 Communication Difficulties: Hearing / Sight / Speech etc.
 Is child fully immunised? Yes / No _____ Record sighted. Yes / No Initials: _____

Details of any dietary requirements / any special considerations eg. Cultural, Religious, dietary for the child

1 _____

2 _____

3 _____

Declaration

- * I/We agree that neither **CHILWELL PRIMARY SCHOOL** nor it's officers and servants will be liable for any damage or injury howsoever caused or of whatsoever nature that may be incurred by any of my children in attendance at any program or any of the activities in connection with the said program.
 - * I/ We understand the responsibility for any costs involved and understand that all fees must be paid In advance.
 - * I/We realise that it is my responsibility to inform the program if my child contracts any illness which could be detrimental to the health of others at the program. I/we agree to allow our child/children to view PG rated movies.
 - * I/ We understand that the program is run by the Sunsmart policy. 'No Hat, no outside play!'
 - * In case of an emergency I agree to my children being transported by ambulance service.
 - * In case of an injury or accident being sustained by the child, I authorise the Co-ordinator or Assistants of the Chilwell Primary School Outside School Hours Care Program, where it is impracticable to communicate with me, to obtain such medical or surgical treatment as may be deemed necessary and agree to meet any expenses, such as transport by an ambulance service.
 - * I consent to the proprietor to seek medical treatment for the child from a medical practitioner, hospital service or ambulance
 - * I also accept full responsibility for my child's belongings whilst attending this program.
 - * I fully understand that if my child continuously misbehaves and after behavior guidance procedures have been followed, I will be notified and my child may be removed from the program.
 - * I understand that all enrolment details are private and confidential.
 - * I give permission for my child to use another room when the Multi Purpose Room is not available. This information will be used for Program purposes only and will be accessible to OOSHC staff, Committee of Management, and teaching staff, the Principal and/or the sponsoring body.
- I understand that I can access this information and correct any necessary details whenever I wish.
- * I consent to photographs (still or video) being taken of my child/ren as part of the OSHC program and to be displayed around the OSHC site on display boards. YES / NO

Signature: _____ *Parent/Guardian* **Date:** / /

Days Required:	BEFORE SCHOOL	AFTER SCHOOL	PERMANENT	CASUAL
MONDAY				
TUESDAY				
WEDNESDAY				
THURSDAY				
FRIDAY				

REGISTRATION FEE: \$10.00 per family

REFUNDABLE DEPOSIT

It has been decided that for any new families using the program a refundable **\$50.00 bond** will be applied. This will either be refunded or taken off the final account when the family exits the program.