

Before and After School Care – Enrolment Form

Account Information					
Account Name:					
Child's Name:					
Commencement Date:					
Before School Care Bookings:	Monday	Tuesday	Wednesday	Thursday	Friday
After School Care Bookings:	Monday	Tuesday	Wednesday	Thursday	Friday
Account Email Address:					

Parent/Guardian 1 Details			
Full Name:			
Parent CRN:			
Parent Medicare Number:			
Private Health Cover:		Yes	No
Home Phone Number:		Mobile:	
Email Address:			
Date of Birth:			
Address:		Postcode:	
Occupation:		Work Phone:	
Primary Language Spoken:		Nationality:	
Cultural Background:		Religion:	
Does the child live with parent /guardian 1?		Yes	No
Are there any court orders pertaining to this child?		Yes	No

Parent/Guardian 2 Details			
Full Name:			
Parent CRN:			
Parent Medicare Number:			
Private Health Cover:		Yes	No
Home Phone Number:		Mobile:	
Email Address:			
Date of Birth:			
Address:		Postcode:	
Occupation:		Work Phone:	
Primary Language Spoken:		Nationality:	
Cultural Background:		Religion:	
Does the child live with parent /guardian 2?		Yes	No
Are there any court orders pertaining to this child?		Yes	No



(Other than listed on page 1 of the family enrolment form).
See section 170(5) of the Law and sections 160, 161,102 and 99 of the Regulations.

Authorised Nominee 1 - The person is to be over the age of 18 and authorised to carry out the following responsibilities for my child.

Full Name:		<input type="checkbox"/> Consent to medical treatment, and authorised to administer medication. <input type="checkbox"/> Authorise an educator to take the child outside of the education and care services premises e.g. excursion/s. <input type="checkbox"/> Collect the child from the education and care service.
Relationship with child:		
Address:		
Home Phone:		
Mobile:		
Work Phone:		
Date of Birth:		
Licence Number:		

Authorised Nominee 2 - The person is to be over the age of 18 and authorised to carry out the following responsibilities for my child.

Full Name:		<input type="checkbox"/> Consent to medical treatment, and authorised to administer medication. <input type="checkbox"/> Authorise an educator to take the child outside of the education and care services premises e.g. excursion/s. <input type="checkbox"/> Collect the child from the education and care service.
Relationship with child:		
Address:		
Home Phone:		
Mobile:		
Work Phone:		
Date of Birth:		
Licence Number:		

Authorised Nominee 3 - The person is to be over the age of 18 and authorised to carry out the following responsibilities for my child.

Full Name:		<input type="checkbox"/> Consent to medical treatment, and authorised to administer medication. <input type="checkbox"/> Authorise an educator to take the child outside of the education and care services premises e.g. excursion/s. <input type="checkbox"/> Collect the child from the education and care service.
Relationship with child:		
Address:		
Home Phone:		
Mobile:		
Work Phone:		
Date of Birth:		
Licence Number:		

Authorised Nominee 4 - The person is to be over the age of 18 and authorised to carry out the following responsibilities for my child.

Full Name:		<input type="checkbox"/> Consent to medical treatment, and authorised to administer medication. <input type="checkbox"/> Authorise an educator to take the child outside of the education and care services premises e.g. excursion/s. <input type="checkbox"/> Collect the child from the education and care service.
Relationship with child:		
Address:		
Home Phone:		
Mobile:		
Work Phone:		
Date of Birth:		
Licence Number:		



Child's Details		
Child's Full Name:		
Child's Address:		
Name child is known as:		
Date of Birth:		
Child's CRN:		
Child's Medicare Number:		
Child's Country of Birth:		
Background: <input type="checkbox"/> Not Aboriginal or Torres Strait Islander <input type="checkbox"/> Aboriginal not Torres Strait Islander <input type="checkbox"/> Torres Strait Islander not Aboriginal <input type="checkbox"/> Aboriginal and Torres Strait Islander		
Languages spoken at home:		
Are there any religious/cultural practices that you wish to bring to the centre to be aware of? Yes/No If yes, please provide details.		
Are there any physical disability/special needs? Yes/No If yes, please provide details.		
Please provide any other information about your child that you feel IGS – BASC should know (i.e. favourite activities, phobias etc.)		
Are there any current written custody arrangements?	Yes/No	<input type="checkbox"/> Copy Provided
Is there anyone legally denied access to the child?	Yes/No	<input type="checkbox"/> Copy Provided
Full name of person legally denied access:		

Cultural Connections and Family Traditions	
Does your family observe any particular religious or cultural practices that are significant to your child?	
Do you celebrate any cultural religious traditions? How do you celebrate these traditions? i.e. Easter, Christmas	
What family traditions do you celebrate?	

Sibling Details			
Child's Name	Date of Birth	Gender	School/Kindergarten services attended



Medical Information				
Child's Full Name:				
Does your child regularly experience any of the following? Please <input checked="" type="checkbox"/> and provide details in the space below. If yes, and individual action / medical care plan by an authorised medical practitioner maybe required.				
Known Allergies No/Yes	What triggers the allergic reaction?			
	<input type="checkbox"/> Mild <input type="checkbox"/> Severe <input type="checkbox"/> Anaphylactic (Epipen must be provided to the service at all times child is in care).			
	Symptoms:			
	Please provide details of any allergy management plans.			
	Action plan attached: Yes / No (A current year action plan required from medical practitioner together with a current photo of the child is required in order to proceed with enrolment).			
Dietary Requirements	Requirements: Please provide details.			
Intolerances No/Yes	What is the cause for the intolerance?			
	<input type="checkbox"/> Mild or <input type="checkbox"/> Severe <input type="checkbox"/>			
	Symptoms:			
	Current action plan/s (please provide details)			
Asthma No/Yes	<input type="checkbox"/> Mild or <input type="checkbox"/> Severe <input type="checkbox"/>			
	What symptoms does your child present with when experiencing Asthma:			
	Action plan attached: Yes/No (A current year action plan required from medical practitioner together with a current photo of the child is required in order to proceed with enrolment).			
Immunisation status up to date No/Yes If you have selected NO you agree that your child will be excluded from the Centre during an outbreak of a disease that is in the Vaccination Schedule.	Hepatitis B	No/Yes	HIB	No/Yes
	Measles, Mumps, and Rubella	No/Yes	Pneumococcal	No/Yes
	Whooping Cough	No/Yes	Rotavirus	No/Yes
	Diphtheria, Tetanus and Pertussis	No/Yes	Meningococcal C	No/Yes
	Polio	No/Yes	Varicella	No/Yes
	If your child's immunisation status is not up to date your eligibility to receive Child Care Benefit from Centrelink may be affected.			
Child Health Record sighted:				No/Yes
Immunisation Certificate sighted:				No/Yes



Other Medical Conditions				
Behavioural	Y		N	(ACHD, OCD, ADD, ADHD etc.)
Blood Disorder	Y		N	
Childhood Illnesses	Y		N	
Congenital Condition	Y		N	
Cardiac Condition	Y		N	
Diabetes	Y		N	
Ear, Nose and Throat Conditions	Y		N	(Hearing Difficulties, Epistaxis, Tonsillitis, etc.)
Epilepsy	Y		N	
Eye Conditions	Y		N	(Colour Blindness, Glasses, Surgery, Corrective Lenses etc.)
Headaches/Migraines	Y		N	
Injuries	Y		N	(Bone Fractures etc.)
Malaria	Y		N	
Muscular/Skeletal	Y		N	(Back, Knee, Hip, Leg, Shoulder, Arm, Wrist, Joint Pain, Other.)
Other Conditions	Y		N	

Medication	
Does your child have regular medication?	No/Yes
Please provide a letter from the doctor with full details.	
Medication administered at the centre will only be administered when there is a chemist label with the child's name, dosage and time frame to be given. Parent/Guardians must also complete the centre medication/administration form.	
I am fully aware that the Educator at Ipswich Grammar School BASC can administer the required number of puffs of an asthma puffer in the event of a medical emergency asthma attack or breathing difficulties. Parent Signature..... Date.....	
I am fully aware that if my child has an allergic reaction (anaphylaxis) the Centre are to call an ambulance service and then notify myself. Parent Signature _____ Date _____	
Application of Topical Treatments Do you provide permission for the service to apply the following? Sunscreen (30+ broad spectrum, water resistant) Insect repellent Antiseptic cream Stingos Band-Aids Ice	No/Yes No/Yes No/Yes No/Yes No/Yes No/Yes



Medical Contacts		
Child's Doctor Details	Name:	
	Name of Practice:	
	Address:	
	Phone Number:	
Child's Dentist Details	Name:	
	Name of Practice:	
	Address:	
	Phone Number:	

I hereby accept responsibility to advise Ipswich grammar School BASC in writing of any changes to information provided by me in this form that may have bearing on health, care and safety of my child whilst in care.

Parent/Guardian 1 Name..... Signed..... Date

Parent/Guardian 2 Name..... Signed..... Date

Family Involvement	
In which way would you be willing to support your child's program and Ipswich Grammar School BASC?	
Music, cooking, gardening and sustainability, sports, art and creativity, building, and sewing.	<input type="checkbox"/> Volunteer in the program
Please specify any other way you would like to help the centre.	<input type="checkbox"/> Other

Accounts and Correspondence	
<p>I understand the Ipswich Grammar School BASC only accept Direct Debit for payment of fees which will be debited from my nominated account weekly/fortnightly as specified.</p> <p>Non-payment of accounts may result in a cancellation of my child's booking.</p> <p>Parent Name.....</p> <p>Signed.....</p>	<p>Please direct my fee and account correspondence to:</p> <p>Email.....</p> <p>Date.....</p>



Miscellaneous

It is a regulatory requirement that parents provide authorisation for emergency medical attention whilst their children are in our care.

- a) I hereby understand and give authorisation for a staff member of the centre to provide appropriate medical attention for my child in an emergency (Inclusive of First Aid).
- b) Ambulance transport to be called if my child requires emergency hospital treatment.
- c) Evacuation in an emergency situation.

Please note: that all medical expenses incurred will be at the expense of the parent. It is also understood that at the time of incident every effort will be made to contact Parents/guardians or emergency contacts and inform them of such incident.

I consent/ do not consent for my child's photograph or audio visual recording to be used for centre purposes.

I give permission/ do not give permission for my child to participate in short walks/excursions planned as part of the centre's program within the centre's grounds. (Ovals, etc.) Please note that parents will receive separate forms outlining details and requesting permission before any outside excursions involving children leaving the school proceed.

I have read and understood the enrolment form and the Before and After School Care Parent Handbook and agree to abide by centre procedure and policies.

I have completed the above information and attached any relevant documentation.

Please comment on any special condition/s that stop you from giving permission for any of these statement listed above:

Parent/Guardian 1 Name:

Guardian /Parent 1 Signature:

Parent/Guardian 2 Name:

Guardian /Parent 2 Signature:

Date:

All information contained within this document is collected for the operational purposes of Ipswich Grammar School, particularly Before & After School Care, and shall be used solely for these purposes in accordance with Privacy Legislation and the subsequent IGS policies pertaining to it.

