

OUTSIDE SCHOOL HOURS CARE

ENROLMENT FORM

Date of Application:

ONE FORM PER STUDENT

CARBROOK CAMPUS

SPRINGWOOD CAMPUS

CHILD DETAILS

CHILD'S BIRTH SURNAME				CHRISTIAN NAMES			
DATE OF BIRTH				PREFERRED CHRISTIAN NAME			
CHILD'S ADDRESS				COUNTRY OF BIRTH			
GENDER		M	F	CRN Number			
Is English a second language?		YES	NO	Language spoken at home?			
Does this student identify as Aboriginal?		YES	NO	I consent for photographs of my child to be used for promotional purposes for the College		YES	NO
Does this student identify as Torres Strait Islander?		YES	NO	CULTURAL BACKGROUND Does your child have any requirements arising from the culture or religion of the child's family?		YES	NO
Does this student identify as both Aboriginal and Torres Strait Islander?		YES	NO	Please detail the child's cultural background if known			
SIBLINGS Please list any siblings attending Calvary Christian College. Please include name and class.							
DATE OF COMMENCEMENT OF CARE Please note: Your child will be enrolled for care from this date							
AM CARE	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY		
PM CARE	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY		
<p>PLEASE NOTE: If your child is enrolled for an OSHC session and is absent, notification must be received by 1.00pm on the session day for after school care or 6.00pm on the day prior for before school care. Failure to do so will result in the attendance being charged. All notifications are to be sent in writing via email to carbroom.oshc@calvarycc.qld.edu.au or springwood.oshc@calvarycc.qld.edu.au.</p> <p>Thank you for your cooperation.</p>							

FAMILY DETAILS

FATHER/LEGAL GUARDIAN:		MOTHER/LEGAL GUARDIAN:	
ADDRESS		ADDRESS	
POSTAL (if different)		POSTAL (if different)	
PHONE (home)	PHONE (work)	PHONE (home)	PHONE (work)
MOBILE		MOBILE	
EMAIL		EMAIL	
<i>As accounts and other important information is sent via email, please ensure the listed emails remain active and are checked regularly.</i>			
CURRENT OCCUPATION		CURRENT OCCUPATION	
MARITAL STATUS	CRN Number	MARITAL STATUS	CRN Number
<i>Married Single Widowed</i>		<i>Married Single Widowed</i>	
<i>Divorced Separated (circle)</i>	Date of Birth	<i>Divorced Separated (circle)</i>	Date of Birth
Are there any Court Orders, Domestic Violence Orders, Parent Agreements, Shared Living Arrangements or any other orders pertaining to the child?			
YES	NO	If yes, please provide details and copies of orders.	

EMERGENCY CONTACTS / NOMINEES: *(other than the parents of the child)* The people named below have been notified that the Service may call upon them and have agreed to be available to collect my/our children from the Service if I/we are unavailable.

EMERGENCY CONTACT / NOMINEE 1			
NAME		RELATIONSHIP	
ADDRESS			
CONTACT PHONE NOS			
I GIVE PERMISSION FOR THIS PERSON TO AUTHORISE ADMINISTRATION OF MEDICATION TO MY CHILD			<input type="checkbox"/> YES <input type="checkbox"/> NO
I GIVE PERMISSION FOR THIS PERSON TO AUTHORISE CONSENT FOR MY CHILD TO RECEIVE MEDICAL TREATMENT			<input type="checkbox"/> YES <input type="checkbox"/> NO
I GIVE PERMISSION FOR THIS PERSON TO AUTHORISE AN EDUCATOR TO TAKE MY CHILD OUTSIDE THE SERVICE			<input type="checkbox"/> YES <input type="checkbox"/> NO
EMERGENCY CONTACT / NOMINEE 2			
NAME		RELATIONSHIP	
ADDRESS			
CONTACT PHONE NOS			
I GIVE PERMISSION FOR THIS PERSON TO AUTHORISE ADMINISTRATION OF MEDICATION TO MY CHILD			<input type="checkbox"/> YES <input type="checkbox"/> NO
I GIVE PERMISSION FOR THIS PERSON TO AUTHORISE CONSENT FOR MY CHILD TO RECEIVE MEDICAL TREATMENT			<input type="checkbox"/> YES <input type="checkbox"/> NO
I GIVE PERMISSION FOR THIS PERSON TO AUTHORISE AN EDUCATOR TO TAKE MY CHILD OUTSIDE THE SERVICE			<input type="checkbox"/> YES <input type="checkbox"/> NO
EMERGENCY CONTACT / NOMINEE 3			
NAME		RELATIONSHIP	
ADDRESS			
CONTACT PHONE NOS			
I GIVE PERMISSION FOR THIS PERSON TO AUTHORISE ADMINISTRATION OF MEDICATION TO MY CHILD			<input type="checkbox"/> YES <input type="checkbox"/> NO
I GIVE PERMISSION FOR THIS PERSON TO AUTHORISE CONSENT FOR MY CHILD TO RECEIVE MEDICAL TREATMENT			<input type="checkbox"/> YES <input type="checkbox"/> NO
I GIVE PERMISSION FOR THIS PERSON TO AUTHORISE AN EDUCATOR TO TAKE MY CHILD OUTSIDE THE SERVICE			<input type="checkbox"/> YES <input type="checkbox"/> NO

It is vitally important, in the case of emergency or illness, that this section has been fully completed.

CHILD MEDICAL DETAILS

MEDICARE NUMBER													
PRIVATE HEALTH INSURANCE PROVIDER													
PRIVATE HEALTH INSURANCE NUMBER													
CHILD'S DOCTOR		NAME											
		ADDRESS											
		PHONE NUMBER											
IF YOUR CHILD HAS ASTHMA						Is Ventolin or other inhaler required daily?				YES		NO	
						Asthma Action Plan supplied				YES		NO	
Does your child have any chronic illness, physical disability or learning disability?		YES		NO		If yes, please state details							
Does your child have any of the following: (If yes, please attach full details, including medical report, treatment and medication required). Describe what the implications may be for the child at the Service.													
Allergies / Anaphylaxis		YES		NO		ADD / ADHD				YES		NO	
Food Intolerances		YES		NO		Respiratory Problems				YES		NO	
Diabetes		YES		NO		Blood Pressure				YES		NO	
Epilepsy		YES		NO		Phobias				YES		NO	
Heart Problems		YES		NO		Chronic Ailments				YES		NO	
Hearing Impairment		YES		NO		Learning Difficulty				YES		NO	
Autism Spectrum Disorder		YES		NO		Dyslexia				YES		NO	
Physical Impairment		YES		NO		Social/Emotional Disorder				YES		NO	
Speech Language Impairment		YES		NO		Intellectual Impairment				YES		NO	
Other (please detail below)													
PLEASE NOTE: If you select yes for any of the above, you will be required to participate in preparing a Risk Minimization Plan in consultation with the Coordinator and relevant staff.													
If yes, to any of the above, please comment below. (Please attach further medical information if necessary – Anaphylaxis Action Plan required if applicable). Details:													
VACCINATIONS: Immunisation History statement supplied										YES		NO	
Has your child been assessed by any of the following Specialist Services or needed the services of?													
Audiologist		YES		NO		Speech Pathologist				YES		NO	
Ear Nose Throat Specialist		YES		NO		Occupational Therapist				YES		NO	
Optometrist		YES		NO		Paediatrician				YES		NO	
Other: _____		YES		NO		Physiotherapist				YES		NO	
Details:													
SPECIAL NEEDS Is your child currently receiving, or has your child ever received, funding or extra help. If yes, please state category and level. Category (eg HI, VI, PI, ASD)						YES			NO				
						Details							
Parental Consent for the Administration of Life Saving Medication													
In the case of an emergency, I give permission for my child, _____ to receive life saving medication (eg. EpiPen, Ventolin)													
Parent Name: _____ Parent Signature: _____ Date: _____													
I authorise the Approved Provider, Nominated Supervisor or an educator to seek medical treatment for my child from a registered medical practitioner (includes dentist), hospital or ambulance service, and/or to transport my child by ambulance in an emergency.													
Parent Name: _____ Parent Signature: _____ Date: _____													

ENROLMENT PROCESS

- Please ensure:
 - ✓ You have read the Outside School Hours Care Parent Manual
 - ✓ You have answered all questions correctly
 - ✓ You attach all required items and return to Outside School Hours Care
- Please also note that it is a condition of this Application, that *two weeks written notice is required for withdrawal of a child from the Service*. Failure to do so may result in an amount equal to two weeks fees being charged in lieu of notice.

STANDARD COLLECTION NOTICE

1. Some of the information we collect is to satisfy the College's legal obligations, particularly to enable the College to discharge its duty of care.
2. Certain laws governing or relating to the operation of childcare centres require that certain information is collected. These include Public Health [and Child Protection]* laws.
3. Health information about pupils is sensitive information within the terms of the National Privacy Principles under the Privacy Act. We ask you to provide medical reports and information about pupils and to keep these updated.
4. If we do not obtain the information referred to above we may not be able to enrol or continue the enrolment of your son/daughter.
5. Personal information collected from pupils is regularly disclosed to their parents or guardians. On occasions information such as achievements, activities, other news and photographs are published in Service and College newsletters, magazines and on our website.
6. Parents may seek access to personal information collected about them and their son/daughter by contacting the Service. However, there will be occasions when access is denied. Such occasions would include where access would have an unreasonable impact on the privacy of others, where access may result in a breach of the Service's duty of care to the child, or when information is provided in confidence.
7. If you provide the Service with the personal information of others, such as doctors or emergency contacts, we encourage you to inform them that you are disclosing that information to the Service and why, that they can access that information if they wish and that the Service does not usually disclose the information to third parties.

PRIVACY STATEMENT: This information is collected for the primary purpose of assisting the Service to provide a Christian environment to families and to ensure staff fulfil their role of duty of care and administration responsibilities. Calvary Christian College abides by the National Privacy Act 2001. For further information please do not hesitate to contact the Service Administration.

CONDITIONS OF ENROLMENT

1. **COLLEGE ETHOS**
To support the mission, aims, policies and Christian ethos of the College and Outside School Hours Care.
2. **FEES PAYMENT**
To be responsible jointly for the payment of all specified OSHC fees applicable to the care of the child/ren named on this form during his/her enrolment at Outside School Hours Care. I/We agree to make fee payments no later than the due dates as specified on each fortnightly invoice.
3. **WITHDRAWAL FROM THE SERVICE**
To submit two weeks written notice prior to withdrawing the named child from the Service. In default of two weeks' notice, I/we will pay the equivalent of two full week fees.
4. **CHANGE OF RELATIONSHIP**
To inform the Service if there is a change in the marital relationship (e.g. separation or divorce) since the signing of the application form.
5. **CHANGE OF ADDRESS AND/OR PHONE NUMBERS**
To notify the Service immediately of any changes that may occur in the details of this form. This must be done formally using the Alteration to Student/Family Details Form.

PARENT / GUARDIAN DECLARATION

I/we have read, understood and agree to abide by the Conditions of Enrolment. I/we understand that failure to fully and frankly disclose any medical, educational, financial or other information relevant to this enrolment may result in termination of the enrolment. I/we also acknowledge, by signing this agreement, I/we agree to work in partnership with the Service in the best interests of our child and the OSHC community.

FATHER/LEGAL GUARDIAN

Full Name

Signature

Date

MOTHER/LEGAL GUARDIAN

Full Name

Signature

Date

NB: BOTH PARENTS (AS SHOWN ON BIRTH CERTIFICATE) MUST AGREE TO AND SIGN THIS CONFIRMATION UNLESS COURT ORDERS ARE ATTACHED REGARDING INDIVIDUAL RESPONSIBILITIES ALLOCATED TO THE INDIVIDUAL PARENTS.

Springwood Campus

161 Dennis Road
Springwood Qld 4119
Phone (07) 3808 8368 Fax (07) 3808 9907

Carbrook Campus

559-581 Beenleigh/Redland Bay Road
Carbrook Qld 4130
Phone: (07) 3287 6222 Fax (07) 3287 6030

Postal: PO Box 4157, Loganholme DC Qld 4129