

# OUTSIDE SCHOOL HOURS CARE

## ENROLMENT FORM

Date of Application:

### ONE FORM PER CHILD

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 (Please note enrolment will not be taken without a CRN).			
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	I consent for photographs of my child to be uploaded on the private parents facebook group (only parents in OSHC can see), Story Park and The Weekly Wrap		YES	NO
Does this student identify as both Aboriginal and Torres Strait Islander?		YES	NO	I consent for my child to watch PG rated movies/cartoons while at OSHC. (Staff will use their discretion as well as research to ensure the movie is appropriate for the age level of the children).		YES	NO
<b>CULTURAL BACKGROUND</b> Does your child have any requirements arising from the culture or religion of the child's family?		YES	NO	Please detail the child's cultural background if known: _____			
DATE OF COMMENCEMENT OF CARE: _____				Which parent is this child's CCS attached to? Parent Name: _____			
<input type="checkbox"/> PERMENANT BOOKING <input type="checkbox"/> CASUAL BOOKING							
Before School Care	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY		
After School Care	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY		

**PLEASE NOTE:**

**Permanent booking** - One weeks' notice is required in writing for cancellation of a booking via email to ensure no charge for that absence.

**Casual booking** – One weeks' notice is required in writing for care via email. 48hours notice is required in writing for cancellation of a booking via email to ensure no charge for that absence. In the event of unforeseen circumstances, last minute bookings can be taken if availability allows.

**Vacation Care** – One weeks' notice is required in writing for cancellation of a booking via email to ensure no charge for that absence.

**Public Holidays** – Charges apply to public holidays that are NOT attached to school holidays.

All bookings and cancellations are to be sent via email to [carbroom.oshc@unitingeducation.com.au](mailto:carbroom.oshc@unitingeducation.com.au) or

[springwood.oshc@unitingeducation.com.au](mailto:springwood.oshc@unitingeducation.com.au)

Thank you for your cooperation.

## FAMILY DETAILS

<b>FATHER/LEGAL GUARDIAN:</b>		<b>MOTHER/LEGAL GUARDIAN:</b>	
ADDRESS		ADDRESS	
POSTAL (if different)		POSTAL (if different)	
MOBILE		MOBILE	
PHONE (home)	PHONE (work)	PHONE (home)	PHONE (work)
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 (Circle) <i>Married Single Widowed</i> <i>Divorced Separated</i>	CRN Number  Date of Birth	MARITAL STATUS (Circle) <i>Married Single Widowed</i> <i>Divorced Separated</i>	CRN Number  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. *Any person who is authorised to authorise the education and care service to transport the child or arrange the transportation of the child*

EMERGENCY CONTACT / NOMINEE 1			
NAME		RELATIONSHIP	
ADDRESS			
CONTACT PHONE NUMBER			
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 NUMBER			
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	
<b>EMERGENCY CONTACT / NOMINEE 3</b>			
NAME		RELATIONSHIP	
ADDRESS			
CONTACT PHONE NUMBER			
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.***

<b>CHILD MEDICAL DETAILS</b>					
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		
<b>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.</b>					
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)					
➤ <b>PLEASE NOTE:</b> 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 must be supplied to OSHC with enrolment form

**BIRTH CERTIFICATE:** Birth Certificate must be supplied to OSHC with enrolment form

**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: \_\_\_\_\_

I authorise the educators within the Service to take my child on incursions, visiting and using school sites not included in the Service's certified area.

Parent Name: \_\_\_\_\_ Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

 **COORDINATOR TO SIGN**

I have sighted the received copy of this child's Health Record

\_\_\_\_\_  
(Coordinator's 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 UEELs legal obligations, particularly to enable the UEEL 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 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. Kingdom Kids abides by the National Privacy Act 2001. For further information please do not hesitate to contact the Service Administration.

## CONDITIONS OF ENROLMENT

1. **CENTRE ETHOS**  
To support the mission, aims, policies and Christian ethos of Kingdom Kids 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 weekly 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

## MOTHER/LEGAL GUARDIAN

Full Name

Full Name

Signature

Signature

Date

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.**

# OFFICE USE ONLY

Coordinator to check the following and sign when completed.

- Fully completed enrolment form received
- Immunisation History Record received
- Birth Certificate received
- Enter enrolment into QikKids
- Add email addresses to Master Contact List
- Send 'New Parent Email'

\_\_\_\_\_  
(Coordinator's Signature)

\_\_\_\_\_  
(Date)

### Springwood Campus

161 Dennis Road  
Springwood Qld 4119  
Phone 1300 CALVARY Fax (07) 3808 9907

### Carbrook Campus

559-581 Beenleigh/Redland Bay Road  
Carbrook Qld 4130  
Phone: 1300 CALVARY Fax (07) 3287 6030

**Postal:** PO Box 4157, Loganholme DC Qld 4129