

Outside School Hours Care Enrolment Form



**MATTHEW
FLINDERS**
Anglican College

A parent or guardian who has lawful authority in relation to the child must complete this form. Please notify the Outside School Hours Care Co-ordinator of any changes to this information e.g. address, telephone numbers, emergency contacts etc.

Family Name: _____

Year of Reg: _____

Medical Alert

Child Details

First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____

Male/Female: _____

School Attending: _____ Class: _____

Child CRN: _____

Parent CRN: _____ Parent DOB: _____

Parent Name CRN is connected to: _____

This information is required if you would like to apply for the Child Care Benefit and the Child Care Rebate through The Family Assistance Office

Home Address: _____ Suburb: _____

State: _____ Postcode: _____

Sibling Name: _____ Date of Birth: _____ CRN: _____

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Sibling Name: _____ Date of Birth: _____ CRN: _____

Parent Details

MOTHER Name: _____ FATHER Name: _____

Address: _____ Address: _____

Suburb: _____ Suburb: _____

State & Postcode: _____ State & Postcode: _____

Email: _____ Email: _____

Home Telephone: _____ Home Telephone: _____

Business Telephone: _____ Business Telephone: _____

Mobile Telephone: _____ Mobile Telephone: _____

Authorised Nominee | Emergency Contacts other than those already listed above

Photo identification must be produced upon request from service staff.

Authorised Emergency Contact #1

Full Name: _____

Relationship to Child: _____

Address: _____

Home Telephone: _____

Mobile Telephone: _____

Signature: _____

This person is authorised to provide the following authorisations for my child (please tick appropriate authorities)

- authorise to medical treatment/ authorise administration of medication
- authorise an educator to take the child outside the education and care services premises
- deliver or collect the child to/from the education and care service and authorisation for Qikkids Kiosk



Authorised Emergency Contact #1

Full Name: _____

Relationship to Child: _____

Address: _____

Home Telephone: _____

Mobile Telephone: _____

Signature: _____

This person is authorised to provide the following authorisations for my child (please tick appropriate authorities)

- authorise to medical treatment/ authorise administration of medication
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Booking Details

Day	Permanent Booking	Casual Booking
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

For permanent bookings please specify expected start date: _____

Medical History

Does your child suffer any medical conditions e.g. asthma, epilepsy, diabetes or have any allergies/dietary restrictions? Yes / No

If Yes, please supply details below of condition/allergy. Including medical management plans or action plans:

Is your child fully immunised? Yes / No

Child's Doctor Name:	Child's Doctor Phone:
Child's Doctor Address:	Medicare No:

A copy of vaccination certificate is required.

Does your child have any special needs staff should be aware of including development delays, impairments or diagnosed disabilities? Yes / No

If Yes, please provide details below.



Religious Background

Do you have any special religious beliefs that you would like staff to be aware of? Yes / No

If yes, please provide details below.

Cultural Background

What is the child's primary language spoken at home? _____

Care Arrangements

Relevant documentation may include parenting plans, parental responsibility plans, residence orders and contact order.

Who has legal custody of the child?	
Is anyone prohibited access to the child?	
Are there any court orders in effect? (please supply details)	

- I give permission for my child to watch G and PG rated movies under the supervision of staff.
- I give permission for my child to be photographed by service staff. Photographs will be for service use only on myFlinders and Facebook.
- I give permission for my child/children to participate in activities involving rollerblading, scootering, slip 'n' slide, swimming in the Flinders Aquatic Centre and other specified activities during the school holidays as advertised according to the Vacation Care Program. Parent permission forms are distributed for external excursions leaving College premises and activities at Flinders Aquatic Centre.
- I have read and understand the policy document for Matthew Flinders Outside School Hours Care and agree it is my responsibility to adhere to the Service handbook. I declare that the information in this form is true and correct.
- In the event of the College being unable to contact a parent/guardian or the nominated emergency contact, I give permission for the College to seek medical assistance and/or administration of life saving medication e.g. Adrenaline (Epipen) for treatment of anaphylaxis and Salbutamol inhaler (Ventolin) for the treatment of acute asthma.
- I give permission for my child to attend Outside School Hours Care and agree to pay all fees relating to this service using our direct debit system. I certify that the information is true and accurate and I will notify OSHC of any change to the information supplied.

Signed: _____ Date: _____

Note: All personal records will be stored securely and kept confidential. All information will be strictly limited to use by the service as outlined in the **Information Handling (Privacy and Confidentiality) Policy**.