



Vic Kids Outside School Hours Care
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Enrolment Form

PLEASE COMPLETE A SEPARATE ENROLMENT FORM FOR EACH CHILD

1. CHILD DETAILS

CHILD'S FULL NAME: _____

HOME ADDRESS: _____

DOB: _____ MALE FEMALE DISABILITY: _____

CHILD'S CENTRELINK REFERENCE NUMBER (CRN): _____

2. PARENT/GUARDIAN DETAILS

PARENT/ GUARDIAN 1 - ACCOUNT HOLDER

NAME: _____ DOB: _____

ADDRESS: _____ POSTCODE: _____
(IF DIFFERENT TO CHILD)

PHONE: (H) _____ (WK) _____ (M) _____

GENDER: MALE FEMALE FAMILY CRN: _____

The date of birth and Centrelink reference numbers (CRN) for the account holder and each child are required for the purposes of linking for Child Care Subsidy (CCS). Families MUST be assessed as eligible for Child Care Subsidy, please contact the Family Assistance Office on 13 61 50 for further information.

PARENT/GUARDIAN 2:

NAME: _____ DOB: _____

ADDRESS: _____ POSTCODE: _____
(IF DIFFERENT TO CHILD)

PHONE: (H) _____ (WK) _____ (M) _____

GENDER: MALE FEMALE

ARE THERE ANY PARENTING ORDERS RELATING TO YOUR CHILD? NO YES

HAS A COPY OF THE RELEVANT DOCUMENTATION BEEN PROVIDED? NO YES

Relevant documentation may include Parenting Plans, Parental Responsibility Plans, Residence orders and Contact Order

3. EMERGENCY CONTACTS/COLLECTION DETAILS

Please list the details of all persons, other than parents/guardians nominated in Section 2, who are authorised to collect your child and/or can be contacted in case of emergency.

Name: _____	Name: _____
Address: _____	Address: _____
Phone: (H) _____	Phone: (H) _____
(W) _____	(W) _____
(M) _____	(M) _____
Relationship to child: _____	Relationship to child: _____

Name: _____	Name: _____
Address: _____	Address: _____
Phone: (H) _____	Phone: (H) _____
(W) _____	(W) _____
(M) _____	(M) _____
Relationship to child: _____	Relationship to child: _____

4. HEALTH/MEDICAL DETAILS

Does your child have any medical conditions? NO YES

If yes, please provide details: _____

Does your child require regular medication? NO YES

If staff will be required to administer medication, a separate medication authority form is to be completed by the parent/guardian. All medication is to be provided in the original packaging with the child's name and dosage.

Does your child have any allergies? NO YES (If yes, please provide details below)

_____ MILD SEVERE ANAPHYLAXIS

Please provide details of any allergy management plans relating to your child

Does your child experience asthma? NO YES (If yes, indicate severity) MILD SEVERE

Please provide details of any asthma management plans relating to your child

Is your child's immunisation status up to date?

Hepatitis B	<input type="checkbox"/> NO <input type="checkbox"/> YES	Hib	<input type="checkbox"/> NO <input type="checkbox"/> YES
Measles/Mumps/Rubella	<input type="checkbox"/> NO <input type="checkbox"/> YES	Pneumococcal	<input type="checkbox"/> NO <input type="checkbox"/> YES
Whooping Cough	<input type="checkbox"/> NO <input type="checkbox"/> YES	Rotavirus	<input type="checkbox"/> NO <input type="checkbox"/> YES
Diphtheria, tetanus and pertussis	<input type="checkbox"/> NO <input type="checkbox"/> YES	Meningococcal C	<input type="checkbox"/> NO <input type="checkbox"/> YES
Polio	<input type="checkbox"/> NO <input type="checkbox"/> YES	Varicella	<input type="checkbox"/> NO <input type="checkbox"/> YES

Does your child have any specific dietary requirements? NO YES _____

Does your child have any food intolerances or allergies or risk of anaphylaxis? NO YES _____

If yes, is the intolerance/allergy life threatening? NO YES

Does your child have any medical or medical anaphylaxis management plans or risk minimization plan (respect to specific healthcare need, medical condition or allergy)? NO YES

Signature of Approved Provider has sighted the child's health care record:

Persons who are authorized to consent to medical treatment or to authorize administration of medication to the child:

Name:..... Address:.....
Contact Details:.....

Persons who are authorized to authorize an educator to take the child outside of Vic Kids premises:

Name:..... Address:.....
Contact Details:.....

Please provide details of any food intolerance/allergy management plans relating to your child

5. MEDICAL PRACTITIONER DETAILS

Doctor 1 Name: _____ Surgery/Practice Name: _____

Address: _____ Phone number: _____

Doctor 2 Name: _____ Surgery/Practice Name: _____

Address: _____ Phone number: _____

Family Medicare No: _____ Child's Medicare No: : _____

6. ADDITIONAL INFORMATION

Does your child have any religious/cultural needs? NO YES _____

Does your child have any dislikes, fears or phobias? NO YES _____

What is the language(s) used in the child's home? _____

Is your child of Aboriginal or Torres Strait Islander descent? NO YES

Is your child from a non-English speaking background? NO YES NATIONALITY: _____

7. BEHAVIOUR INFORMATION

Does your child have a Positive Behaviour Support Plan? NO YES

Are there any particular behaviours that staff should be aware of? NO YES _____

Are there any identifiable triggers to the behaviour? NO YES _____

Please provide a copy of any Positive Behaviour Support plans relating to your child

8. BEHAVIOUR POLICY

Vic Kids OSHC has a behavior management policy and procedure that encourages children to take positive action for their behavior. Our behavior policy is very similar to Victoria Plantation State School's and we encourage the use of the school's Charter of Expectations in line with the You Can Do It program. Children will conduct themselves in a manner that is courteous and respectful to others at all times. By taking responsibility and accountability of their own actions, the children learn from their experiences. Inappropriate language is unacceptable and will not be tolerated. Any physical behavior directed at staff or other children will also not be tolerated. Children must wear hats and sun safe clothing at all times.

Rules agreed upon by Parents, Students and Staff

- ✓ Don't call out, talk loudly or scream when somebody else is talking
- ✓ Don't run away from educators or parents
- ✓ Always listen to educators, children and adults, treat everyone with respect
- ✓ Don't tell lies, gossip or be unkind to others
- ✓ Don't cause injury to others, always be safe
- ✓ Ensure we are in educators eyesight at all times
- ✓ Accept consequences if we break the rules
- ✓ Don't run on the cement
- ✓ Don't use inappropriate language including swearing
- ✓ Keep your hands and your feet to yourself at all times

I agree to abide by the rules at all times

9. BOOKING INFORMATION

Before School/After School Care/Vacation care: *please indicate*

Permanent days: MON TUES WED THURS FRI

Casual Care:

Vacation Care programs and booking forms are available at least 4 weeks before the vacation care period starts. The program has a mix of in-house activities and excursion days.

10. PERMISSION & AGREEMENT DETAILS

(Please tick the appropriate boxes and initial beside each to signal your agreement)

- I give my consent to the information contained in this document being available to the Educators employed to work with my child on the Outside School Hours Care Program. I understand this information will be handled strictly in accordance with Privacy and Confidentiality Guidelines and will only be shared as a way of improving the quality of service provision to my child.
- I agree to notify the Coordinator, in writing, of any change in circumstances from the details as outlined in this enrolment form, including contact details and living arrangements of my child and/or parent/guardian.
- I understand that it is my responsibility to ensure all Child Care Benefit requirements are fulfilled, in particular, ensuring eligibility for CCB, providing my/our date of birth and providing family and child Customer Reference Numbers.
- I agree to inform the Coordinator of any absence of my child as soon as possible and to pay any fee that may be incurred as a result of not cancelling within the specified timeframes, as set out in the service policy.
- I understand that the nature of the activities will include, but is not limited to, centre based activities/community outings/meal times and that risk may arise during these activities. I understand that I will receive a separate permission form for any excursions.
- I agree to pay for all fees (including excursion costs) of the days that my child attends the program.
- I authorise OSHC staff to provide any required first aid and to facilitate medical attention in the event of an emergency. I give permission for OSHC staff to obtain any medical, hospital and ambulance service in the case of an accident or emergency involving my child and I accept responsibility for payment of all expenses associated with such treatment. I understand that every effort will be made to contact me in the event of any illness or accident.
- I authorise OSHC staff to liaise with other health/medical professionals in relation to the care of my child.
- I agree to keep my child from attending the program should he/she be experiencing any illness or contagious disease.
- I give permission for OSHC staff to assist my child to apply a SPF 30+ sunscreen prior to outdoor activities that I have provided to the service.
- I give permission for staff to take photos of my child to record important events and special activities as part of the program. I understand that these photos will be displayed for the families to see and will also be used for the purposes of programming and evaluation. These photos may also be used on our Secret Family Group facebook site as well as for promotional, including media such as News or Newspaper items on the rare occasion.
- I understand that should my child's behaviour be unable to be supported by staff, that I will be contacted and asked to collect my child.
- I agree to receive promotional material, programs, newsletters and/or account statements via email as listed below.
- I agree to adhere to the services Outside School Hours Care (OSHC) Policies and Procedures, as outlined in the OSHC Family Handbook.
- I consent to the medical treatment of my child, for the approved provider/nominated supervisor or educator to seek the transportation of my child by an ambulance service.

PARENT/GUARDIAN 1:

NAME: _____ SIGNED: _____ DATE: _____

EMAIL ADDRESS: _____

PLEASE PROVIDE A COPY OF YOUR CHILD'S BIRTH CERTIFICATE AND VACCINATION RECORDS

Swimming Ability Form

Name:

Age:.....

Please check the appropriate space and provide comments if necessary.

Comfort level around the water.

Very Comfortable

Comfortable

Uncomfortable

Swimming ability:

- Non-swimmer (cannot support themselves in water)
- Novice (can support themselves in shallow water and are capable of moving short distances <5m)
- Intermediate (can support themselves in deep water and can swim a length of a pool)
- Advanced (can support themselves in deep water and can swim any lengths of the pool)

Please indicate any special needs or disabilities:

.....

Name of Parent/Guardian:.....

Signature:..... Date:.....