# ST BERNARD'S OUT OF SCHOOL HOURS CARE INCORPORATED

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Family Account No:

# OSHC ENROLMENT 2023

All information on this document remains confidential and will only be available to authorised educators and emergency personnel. Information will only be released when legally required to do so, and only to those persons with authorised access under the Education and Care Services National Law

**PLEASE COMPLETE ALL SECTIONS CLEARLY IN BLOCK LETTERS**

## SECTION ONE: PARENT/GUARDIAN NOMINATED FOR CCS

TITLE.....FIRST NAME.....SURNAME.....

RELATIONSHIP..... DATE OF BIRTH.....

CRN: ..... COUNTRY OF BIRTH.....

ADDRESS..... SUBURB..... POSTCODE.....

PHONE: (H)..... (W)..... (MOB).....

OCCUPATION..... EMAIL ADDRESS.....

## PARENT/GUARDIAN TWO DETAILS

TITLE.....FIRST NAME.....SURNAME.....

RELATIONSHIP..... DATE OF BIRTH.....

COUNTRY OF BIRTH.....

ADDRESS..... SUBURB..... POSTCODE.....

PHONE: (H)..... (W)..... (MOB).....

OCCUPATION..... EMAIL ADDRESS.....

## SECTION TWO: BILLING

I AGREE TO PAY MY OSHC FEES VIA THE DEBITSUCCESS DIRECT DEBIT SYSTEM YES ☐

I AGREE TO RECEIVE MY OSHC ACCOUNT VIA EMAIL YES ☐

## SECTION THREE: EMERGENCY CONTACTS/AUTHORISED NOMINEES* *OTHER THAN PARENTS IN SECTION ONE*

| EMERGENCY CONTACT ONE/ kiosk enabled ☐ | EMERGENCY CONTACT TWO/ kiosk enabled ☐ | EMERGENCY CONTACT THREE/ kiosk enabled ☐ |
|---|---|---|
| Title.....Name.....<br>Surname..... | Title.....Name.....<br>Surname..... | Title.....Name.....<br>Surname..... |
| ADDRESS: | ADDRESS: | ADDRESS: |
| Mobile..... | Mobile..... | Mobile..... |
| Relationship to Child: | Relationship to Child: | Relationship to Child: |
| Is this person authorised to collect your child/ren from our service? Y☐ N☐<br>Parent Signature..... | Is this person authorised to collect your child/ren from our service? Y☐ N☐<br>Parent Signature..... | Is this person authorised to collect your child/ren from our service? Y☐ N☐<br>Parent Signature..... |
| Is this person authorised to consent to medical treatment /administration of medication to your child/ren? Y☐ N☐<br>Parent Signature..... | Is this person authorised to consent to medical treatment /administration of medication to your child/ren? Y☐ N☐<br>Parent Signature..... | Is this person authorised to consent to medical treatment /administration of medication to your child/ren? Y☐ N☐<br>Parent Signature..... |
| Is this person authorised to authorise an educator to take your child/ren outside of the OSHC premises? Y☐ N☐<br>Parent Signature..... | Is this person authorised to authorise an educator to take your child/ren outside of the OSHC premises? Y☐ N☐<br>Parent Signature..... | Is this person authorised to authorise an educator to take your child/ren outside of the OSHC premises? Y☐ N☐<br>Parent Signature..... |

## SECTION FOUR: CHILD ONE DETAILS

FIRST NAME..... SURNAME.....

GENDER: MALE ☐ FEMALE ☐ DATE OF BIRTH..... CRN: .....

CHILD'S COUNTRY OF BIRTH..... GRADE .....SCHOOL.....

CHILD'S RESIDENTIAL ADDRESS: .....

CHILD RESIDES WITH: BOTH PARENTS☐ MOTHER☐ FATHER☐ GUARDIAN☐

ARE THE CHILD'S PARENT/GUARDIAN DETAILS THE SAME AS IN SECTION ONE? YES☐ NO☐

IF NO, PLEASE SUPPLY NAME, ADDRESS AND CONTACT DETAILS OF PARENTS/GUARDIANS

PARENT 1 ..... PARENT 2 .....

ADDRESS..... ADDRESS.....

CONTACT DETAILS.....CONTACT DETAILS: .....

RELATIONSHIP TO THE CHILD..... RELATIONSHIP TO THE CHILD.....

MEDICAL INFORMATION

DOES YOUR CHILD SUFFER FROM A DIAGNOSED MEDICAL CONDITION THAT OUR SERVICE STAFF NEED TO BE AWARE OF?

Anaphylaxis, Asthma, ASD, ADHD, Medical Allergies, Food Allergies, Diabetes, Epilepsy or other? YES☐ NO☐

**IF YES**, PLEASE PROVIDE A CURRENT MANAGEMENT/ACTION PLAN SIGNED BY YOUR GP. Plan provided YES☐ NO☐

DOES YOUR CHILD REQUIRE MEDICATION FOR HIS/HER MEDICAL CONDITION? YES☐ NO☐

**IF YES**, PLEASE PROVIDE *MEDICATION AS INDICATED ON THE ACTION PLAN- Medication to be kept at the service for your child's use

*MEDICATION PRESCRIBED BY A GP MUST BE PROVIDED IN IT'S ORIGINAL PACKAGING WITH CHILD'S NAME AND EXPIRY DATE

IMMUNISATION STATUS

HAS YOUR CHILD BEEN IMMUNISED? YES☐ NO☐

## CHILD TWO DETAILS

FIRST NAME..... SURNAME.....

GENDER: MALE ☐ FEMALE ☐ DATE OF BIRTH..... CRN: .....

CHILD'S COUNTRY OF BIRTH..... GRADE .....SCHOOL.....

CHILD'S RESIDENTIAL ADDRESS: .....

CHILD RESIDES WITH: BOTH PARENTS☐ MOTHER☐ FATHER☐ GUARDIAN☐

ARE THE CHILD'S PARENT/GUARDIAN DETAILS THE SAME AS IN SECTION ONE? YES☐ NO☐

IF NO, PLEASE SUPPLY NAME, ADDRESS AND CONTACT DETAILS OF PARENTS/GUARDIANS

PARENT 1 ..... PARENT 2 .....

ADDRESS..... ADDRESS.....

CONTACT DETAILS.....CONTACT DETAILS: .....

RELATIONSHIP TO THE CHILD..... RELATIONSHIP TO THE CHILD.....

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Anaphylaxis, Asthma, ASD, ADHD, Medical Allergies, Food Allergies, Diabetes, Epilepsy or other? YES☐ NO☐

**IF YES**, PLEASE PROVIDE A CURRENT MANAGEMENT/ACTION PLAN SIGNED BY YOUR GP. Plan provided YES☐ NO☐

DOES YOUR CHILD REQUIRE MEDICATION FOR HIS/HER MEDICAL CONDITION? YES☐ NO☐

**IF YES**, PLEASE PROVIDE *MEDICATION AS INDICATED ON THE ACTION PLAN- Medication to be kept at the service for your child's use

*MEDICATION PRESCRIBED BY A GP MUST BE PROVIDED IN IT'S ORIGINAL PACKAGING WITH CHILD'S NAME AND EXPIRY DATE

IMMUNISATION STATUS

HAS YOUR CHILD BEEN IMMUNISED? YES☐ NO☐

CHILD THREE DETAILS

FIRST NAME..... SURNAME.....

GENDER: MALE ☐ FEMALE ☐ DATE OF BIRTH..... CRN: .....

CHILD'S COUNTRY OF BIRTH..... GRADE .....SCHOOL.....

CHILD'S RESIDENTIAL ADDRESS: .....

CHILD RESIDES WITH: BOTH PARENTS☐ MOTHER☐ FATHER☐ GUARDIAN☐

ARE THE CHILD'S PARENT/GUARDIAN DETAILS THE SAME AS IN SECTION ONE? YES☐ NO☐

IF NO, PLEASE SUPPLY NAME, ADDRESS AND CONTACT DETAILS OF PARENTS/GUARDIANS

PARENT 1 ..... PARENT 2 .....

ADDRESS..... ADDRESS.....

CONTACT DETAILS.....CONTACT DETAILS: .....

RELATIONSHIP TO THE CHILD..... RELATIONSHIP TO THE CHILD.....

MEDICAL INFORMATION

DOES YOUR CHILD SUFFER FROM A DIAGNOSED MEDICAL CONDITION THAT OUR SERVICE STAFF NEED TO BE AWARE OF?

Anaphylaxis, Asthma, ASD, ADHD, Medical Allergies, Food Allergies, Diabetes, Epilepsy or other? YES☐ NO☐

**IF YES**, PLEASE PROVIDE A CURRENT MANAGEMENT/ACTION PLAN SIGNED BY YOUR GP. Plan provided YES☐ NO☐

DOES YOUR CHILD REQUIRE MEDICATION FOR HIS/HER MEDICAL CONDITION? YES☐ NO☐

**IF YES**, PLEASE PROVIDE *MEDICATION AS INDICATED ON THE ACTION PLAN- Medication to be kept at the service for your child's use

*MEDICATION PRESCRIBED BY A GP MUST BE PROVIDED IN IT'S ORIGINAL PACKAGING WITH CHILD'S NAME AND EXPIRY DATE

IMMUNISATION STATUS

HAS YOUR CHILD BEEN IMMUNISED? YES☐ NO☐

## SECTION FIVE: CHILD CARE SUBSIDY (CCS)

HAVE YOU COMPLETED A CCS ASSESSMENT IN YOUR CENTRELINK ACC VIA THE MYGOV WEBSITE? YES☐ NO☐

WILL YOU BE CLAIMING CCS AS A FEE REDUCTION THROUGH OUR SERVICE? YES☐ NO☐

FOR FURTHER INFORMATION ON CCS ELIGIBILITY,
PLEASE CONTACT THE FAMILY ASSISTANCE OFFICE ON: 136 150 (8AM-8PM) M-F

## SECTION SIX: FAMILY DOCTOR'S INFORMATION

DOCTOR'S NAME.....

ADDRESS..... PHONE.....

MEDICARE NO..... DO YOU SUBSCRIBE TO AN AMBULANCE SERVICE? YES☐ NO☐

IF YES, PLEASE STATE AMBULANCE SUBSCRIPTION NUMBER AND CATEGORY.....

NAME OF FUND.....

## SECTION SEVEN: AUTHORISATION FOR MEDICAL TREATMENT

| | | |
|---|---|---|
| DO YOU AUTHORISE THE NOMINATED SUPERVISOR OR ANOTHER EDUCATOR AT THE SERVICE TO SEEK MEDICAL TREATMENT FROM A REGISTERED MEDICAL PRACTITIONER, HOSPITAL OR AMBULANCE SERVICE; AND TRANSPORTATION OF THE CHILD BY AN AMBULANCE SERVICE? | YES ☐<br>NO ☐ | Parent one<br>Signature……<br><br>Parent Two<br>Signature…… |
| DO YOU AUTHORISE THE NOMINATED SUPERVISOR OR OTHER EDUCATOR TO ADMINISTER MEDICATION WHICH HAS BEEN PRESCRIBED BY A GP, IS PROVIDED IN IT'S ORIGINAL PACKAGING AND LABELLED WITH THE CHILD'S NAME AND EXPIRY DATE? | YES ☐<br>NO ☐ | Parent one<br>Signature……<br><br>Parent Two<br>Signature…… |

## SECTION EIGHT: CUSTODY AND ACCESS DETAILS

ARE THERE ANY RESTRAINING ORDERS RELATING TO ANY OF YOUR CHILDREN? YES ☐ NO ☐
**IF YES**, PLEASE PROVIDE A COPY OF THE ORDER

ARE THERE ANY SPECIAL ACCESS/CUSTODY ARRANGEMENTS RELATING TO ANY OF YOUR CHILDREN? YES ☐ NO ☐
**IF YES**, PLEASE PROVIDE A COPY OF ANY OF THE FOLLOWING WITH YOUR CHILD'S ENROLMENT
A COURT ORDER, PARENTING ORDER OR PARENTING PLAN AND ANY OTHER RELEVANT CUSTODY DOCUMENTS

IF YOU HAVE ANSWERED **YES** TO EITHER OF THE ABOVE, PLEASE STATE WHICH OF YOUR CHILDREN THIS RELATES TO:

CHILD/REN'S NAMES…….

## SECTION NINE: BOOKING ARRANGEMENT - PERMANENT/ CASUAL

| AFTER SCHOOL CARE | |
|---|---|
| MONDAY | |
| TUESDAY | |
| WEDNESDAY | |
| THURSDAY | |
| FRIDAY | |
| CASUAL | |

| BEFORE SCHOOL CARE | |
|---|---|
| MONDAY | |
| TUESDAY | |
| WEDNESDAY | |
| THURSDAY | |
| FRIDAY | |
| CASUAL | |

| VACATION CARE | |
|---|---|
| CASUAL | |

IF YOU HAVE SELECTED A RE-OCCURING PERMANENT WEEKLY BOOKING,
WHEN WOULD YOU LIKE THIS ARRANGEMENT TO COMMENCE? DATE: _____/_____/ 2023

**PLEASE NOTE:** ABSENCES FROM A PERMANENT OR CASUAL BOOKED SESSION WILL INCUR THE USUAL FEE LESS CCS. TEMPORARY SWAPPING OF PERMANENTLY BOOKED DAYS ARE NOT ALLOWABLE. ANY CHANGES OR CANCELLATIONS TO A PERMANENT BOOKING REQUIRES A MINIMUM OF ONE WEEK'S NOTICE OTHERWISE THE USUAL FEE LESS CCS WILL BE CHARGED

## SECTION TEN: PERMISSION FOR YOUR CHILDREN TO WATCH PG RATED MOVIES AND TV PROGRAMS

INTEGRATED IN OUR WEEKLY PLANNED ACTIVITIES IS THE OPPORTUNITY FOR THE CHILDREN TO ENJOY MOVIES AND TV SHOWS THAT GENERALLY CARRY A G CLASSIFICATION. HOWEVER, MANY OF THE CURRENT MOVIES THAT ARE ON OFFER FOR SCHOOL AGE CHILDREN OCCASIONALLY CARRY A PG CLASSIFICATION.
WITH THIS IN MIND, EDUCATORS TAKE GREAT CARE IN SELECTING APPROPRIATE PG RATED MOVIES FOR THE CHILDREN'S ENJOYMENT; NO MOVIE OR TV SHOW IS SHOWN TO THE CHILDREN UNLESS A PRIOR REVIEW HAS BEEN MADE OF ITS SUITABILITY.

I GIVE PERMISSION FOR MY CHILD/CHILDREN TO WATCH PG CLASSIFIED MOVIES YES ☐ NO ☐

PARENT/CAREGIVER SIGNATURE…….

COMMENTS……

## SECTION ELEVEN: CHILDREN'S PHOTOGRAPHS / VIDEOS / IPAD / SCREEN TIME USAGE

DO YOU AGREE TO HAVE YOUR CHILD/REN TO BE INCLUDED IN PHOTOS/VIDEOS AT OUR SERVICE DURING SPECIAL EVENTS? YES ☐ NO ☐
DO YOU AGREE TO SHARE YOUR CHILD/REN'S IMAGE WITH OTHER OSHC FAMILIES IN THE CASE OF GROUP PHOTOS/VIDEOS? YES ☐ NO ☐
DO YOU AGREE TO HAVE YOUR CHILD/REN'S PHOTO INCLUDED IN THE SCHOOL NEWSLETTER 'BERNARDO'? YES ☐ NO ☐
DO YOU AGREE TO ALLOW YOUR CHILD/REN IPAD/SCREEN TIME (10 MIN MAX)? YES ☐ NO ☐

## SECTION TWELVE: CULTURAL CONSIDERATION

FAMILY COUNTRY/IES OF ORIGIN: ……

PRINCIPAL LANGUAGE SPOKEN AT HOME: ……

DOES YOUR CHILD HAVE ANY SPECIAL FOOD/CULTURAL REQUIREMENTS? YES ☐ NO ☐

IF YES-Please give details……

## SECTION THIRTEEN: SUNSCREEN / BANDAIDS

I GIVE PERMISSION FOR MY CHILD/REN TO USE THE SPF 30/50+ SUNSCREEN PROVIDED BY OSHC ON DAYS WHEN THE UV INDEX IS 3 AND ABOVE YES ☐ NO ☐ IF NO, PLEASE GIVE REASON……

I GIVE PERMISSION TO THE OSHC STAFF TO APPLY A BAND AID TO MY CHILD WHEN REQUIRED YES ☐ NO ☐

## SECTION FOURTEEN: MANAGING CHILD CARE PLACES - CONSIDERATION WHEN OUR SERVICE IS AT FULL CAPACITY

OUR SERVICE PRIORITISES PLACES FOR CHILDREN WHO ARE:

- AT RISK OF SERIOUS ABUSE OR NEGLECT
- A CHILD OF A SOLE PARENT WHO SATISFIES, OR PARENTS WHO BOTH SATISFY, THE CCS ACTIVITY TEST THROUGH PAID EMPLOYMENT.

THIS MEETS THE AUSTRALIAN GOVERNMENT'S AIM TO HELP FAMILIES WHO ARE MOST IN NEED AS WELL AS SUPPORTING THE SAFETY AND WELLBEING OF CHILDREN AT RISK.

## SECTION FIFTEEN: PARENT DOCUMENT /MEDICATION CHECKLIST

| I HAVE PROVIDED THE FOLLOWING DOCUMENTS AND MEDICATION WITH MY CHILD/REN'S ENROLMENT: (PLEASE TICK) | CHILD 1 | CHILD 2 | CHILD 3 |
|---|---|---|---|
| ANAPHYLAXIS MANAGEMENT PLAN | | | |
| EPIPEN | | | |
| ASTHMA MANAGEMENT PLAN | | | |
| ASTHMA MEDICATION | | | |
| SPACER | | | |
| ALLERGY PLAN/INFORMATION | | | |
| ALLERGY MEDICATION | | | |
| DIETARY REQUIREMENTS | | | |
| COURT ORDERS, INCLUDING PARENTING ORDER, PARENTING PLAN, SPECIAL ACCESS | | | |
| CUSTODY ARRANGEMENTS | | | |
| OTHER (PLEASE PROVIDE DETAILS) | | | |
| | | | |
| | | | |

COMMENTS……
……
……

## SECTION SIXTEEN: MEDICAL/ GENERAL DECLARATION (PLEASE READ CAREFULLY AND SIGN BELOW)

I THE UNDERSIGNED APPROVE OF THE ENROLMENT AND AGREE TO ABIDE BY THE RULES AND CONDITIONS OF THE OUT OF SCHOOL HOURS CARE INCORPORATED AND MEET ANY COSTS INCURRED. I AUTHORIZE THE DIRECTOR /ACTING DIRECTOR IN THE EVENT OF ANY UNFORESEEN ACCIDENT OR ILLNESS TO OBTAIN SUCH MEDICAL ASSISTANCE AS IS REQUIRED AND AGREE TO MEET THE EXPENSES ATTACHED TO SUCH TREATMENT.

I ALSO ACCEPT FULL RESPONSIBILITY FOR MY CHILD'S BELONGINGS WHILST ATTENDING THIS PROGRAM. I FULLY UNDERSTAND THAT IF MY CHILD CONTINUOUSLY MISBEHAVES AND AFTER BEHAVIOUR GUIDANCE PROCEDURES HAVE BEEN FOLLOWED, I WILL BE NOTIFIED AND MY CHILD MAY BE REMOVED FROM THE PROGRAM.

I UNDERTAKE TO INFORM THE STAFF OF ANY ABSENCES OF MY CHILD. I ACKNOWLEDGE THAT MY CHILD WILL NOT ATTEND THE PROGRAM IF SUFFERING FROM AN INFECTIOUS OR CONTAGIOUS DISEASE. IN THE EVENT THAT MY CHILD IS INJURED OR BECOMES ILL DURING THE PROGRAM, EITHER AN AUTHORISED PERSON OR I SHALL COLLECT MY CHILD AS SOON AS POSSIBLE.

I ALSO UNDERSTAND THAT AS A REGISTERED USER OF THE SERVICE I AUTOMATICALLY BECOME A MEMBER OF THE ST. BERNARD'S OSHC ASSOCIATION IN ACCORDANCE WITH THE REQUIREMENTS LAID OUT IN THE ST. BERNARD'S OSHC CONSTITUTION 2013 AND THE ASSOCIATIONS INCORPORATION REFORM ACT 2012.
I UNDERSTAND THAT ALL MY ENROLMENT DETAILS ARE STRICTLY PRIVATE AND CONFIDENTIAL.

PARENT/GUARDIAN/CAREGIVER SIGNATURE……DATE……