

**ORMOND PRIMARY SCHOOL OUT OF SCHOOL HOURS PROGRAM  
ENROLMENT FORM 2015**

**Family Name:** \_\_\_\_\_

Childs Details

**Child's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Grade:** \_\_\_\_\_ **Gender:** M  F

**Child Usually Called:** \_\_\_\_\_ **Child's Customer Reference Number:** \_\_\_\_\_

We require a parent & child *Centrelink* Customer Reference Number if you require *Child Care Benefit (Fee Reduction) and/or the 50% Rebate.*

**Child's Country of Birth:** \_\_\_\_\_ **Language Spoken at Home:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

Does this child have a developmental delay or disability including intellectual, including, sensory or physical impairment? (please tick) Yes  No

Parent/Guardian Details

**Mothers Name:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Customer Reference Number:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**Mothers Phone No: H:** \_\_\_\_\_ **W:** \_\_\_\_\_ **M:** \_\_\_\_\_

**Mothers Country of Birth:** \_\_\_\_\_ **Language Spoken at Home:** \_\_\_\_\_

**Mothers Work Details:** F/time  P/time  Study  Home Duties  Other

Does this child live with their mother? (please tick) Yes  No

**Fathers Name:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Customer Reference Number:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**Fathers Phone No: H:** \_\_\_\_\_ **W:** \_\_\_\_\_ **M:** \_\_\_\_\_

**Fathers Country of Birth:** \_\_\_\_\_ **Language Spoken at Home:** \_\_\_\_\_

**Fathers Work Details:** F/time  P/time  Study  Home Duties  Other

Does this child live with their father? (please tick) Yes  No

Only if applicable

**Guardians Name:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Customer Reference Number:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**Guardians Phone No:H:** \_\_\_\_\_ **W:** \_\_\_\_\_ **M:** \_\_\_\_\_

**Guardians Country of Birth:** \_\_\_\_\_ **Language Spoken at Home:** \_\_\_\_\_

**Guardians Work Details:** F/time  P/time  Study  Home Duties  Other

Does this child live with the Guardian? (please tick) Yes  No

**CUSTODY ARRANGEMENTS**

**Child resides with:**      Both Parents      Shared Access      Mother Only      Father Only

(Please Circle)

Parents with shared access may be required to complete another enrolment form please inform the Coordinator of your shared child care requirements.

Details of Custody Arrangements:

*Please provide legal documentation. (Court orders)*

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**Lawful Authority**

(Please Read)

All parents have powers and responsibilities in relation to their children that can only be changed by a court order. The Children’s Services Regulations 2009 refer to these powers and responsibilities as “lawful authority”. It is not affected by the relationship between the parents, such as whether or not they have lived together or are married. A court order, such as under the Family Law Act, may take away the authority of a parent to do something, or may give it to another person.

*Guardians*

A guardian of a child also has lawful authority. A legal guardian is given lawful authority by a court order. The definition of “guardian” under the *Children’s Services Act 1996* also covers situations where a child does not live with his or her parents and there are no court orders. In these cases, the guardian is the person the child lives with who has day-to-day care and control of the child.

**Emergency Contacts**

Please provide two emergency contacts the service can call when the parents cannot be contacted. (Re: Illness, injury or the child remaining at the service after closing time.)

**Name:** \_\_\_\_\_ **Relationship to Child:** \_\_\_\_\_

Home Address: \_\_\_\_\_

Contacts Phone No: **H:** \_\_\_\_\_ **W:** \_\_\_\_\_ **M:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship to Child:** \_\_\_\_\_

Home Address: \_\_\_\_\_

Contacts Phone No: **H:** \_\_\_\_\_ **W:** \_\_\_\_\_ **M:** \_\_\_\_\_

**Authorise Collection of Children**

In addition to the child’s parents who is authorised to collect the child from the service. *Please inform the program when an authorised person is collecting your child from the service.*

**If your require someone not listed on this form to collect your child, please inform the Coordinator in writing.**

**Name:** \_\_\_\_\_ **Relationship to Child:** \_\_\_\_\_

Home Address: \_\_\_\_\_

Contacts Phone No: **H:** \_\_\_\_\_ **W:** \_\_\_\_\_ **M:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship to Child:** \_\_\_\_\_

Home Address: \_\_\_\_\_

Contacts Phone No: **H:** \_\_\_\_\_ **W:** \_\_\_\_\_ **M:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship to Child:** \_\_\_\_\_

Home Address: \_\_\_\_\_

Contacts Phone No: **H:** \_\_\_\_\_ **W:** \_\_\_\_\_ **M:** \_\_\_\_\_

## Medical Details

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Medicare Number: \_\_\_\_\_ Ambulance Membership Number: \_\_\_\_\_

### Child Immunisation Certificate

Does your child have an immunisation certificate? (please tick) Yes  No

**If Yes:** Please provide the service with a copy of the child's immunisation certificate with this enrolment form.  
**(New Children Only)**

**If No: If your child does not have an immunisation certificate you will be required to present a letter of exemption from a doctor.**

### Child Health Information

Does your child have any special needs or additional care requirements? (please tick) Yes  No

**If yes** please provide details and any management procedure to be followed with respect to the child's additional needs.

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### Anaphylaxis

Has your child been diagnosed at risk of anaphylaxis? (please tick) Yes  No

Does your child have an auto injection device (e.g. EpiPen/Anapen)? (please tick) Yes  No

Has an anaphylaxis medical management plan been completed in consultation with a doctor? Yes  No

Have you provide the school with a copy of the anaphylaxis management plan? (please tick) Yes  No

- You are required to provide the school and the service with an individual medical management plan for your child signed by the medical practitioner who is treating your child. This should be attached to your child's enrolment form. More information is available at [www.education.vic.gov.au/anaphylaxis](http://www.education.vic.gov.au/anaphylaxis)

### Allergies

Does your child have any allergies or sensitivity? (please tick) Yes  No

**If yes** please provide details of any allergies and any management procedure to be followed with respect to the allergy.

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Does your child have any other medical conditions? (e.g. asthma, epilepsy, diabetes etc that is relevant to the care of your child? (please tick) Yes  No

**If yes** please provide details of any medical condition and any management procedure to be followed with respect to the medical condition.

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**Asthma Information**

Please provide details of your child’s asthma symptoms:

Have you provided an asthma plan to the school? Yes  No

My child will have asthma medication in their bag when in attendance at the program: (please tick) Yes  No

Name of Medication	Method (e.g. puffer & spacer, tubuhaler)	When & how much?

**Dietary Requirements**

Does the child have any dietary restrictions? Yes  No  (please tick) **If Yes:** Please provide details.

\_\_\_\_\_  
\_\_\_\_\_

**Child’s Interests**

Art & Craft  Drawing  Board Games  Dramatic Play  Construction Toys   
Drama  Music  Structured Games  Reading  Cooking

Other activities your child enjoys: \_\_\_\_\_  
\_\_\_\_\_

**Additional Information**

Parents please provide additional information regarding your child’s interests or other information that may assist the program to accommodate your child.

\_\_\_\_\_  
\_\_\_\_\_

**Specialist Activity Program**

The After School Care Program is funded by the Australian Sports Commission to provide two activity programs per term. Please assist us to provide activities relevant to your child’s interests.

Please tick the activities your child would like to participate in.

Skipping  Circus Skills  Gymnastics  Aerobics  Cheer Leading  Dance   
Athletics  Cricket  Basketball  Soccer  Baseball  Football

\_\_\_\_\_  
\_\_\_\_\_

**BEFORE & AFTER SCHOOL CARE BOOKINGS**

Please read attached booking information before completing this section.

**Before School Care** (7.30am – 8.45am) (Please tick appropriate box) Commencement Date: \_\_\_\_\_

Permanent Daily Basis  Permanent Days Circled  Casual Days & Emergencies   
(Please nominate days) Mon  Tue  Wed  Thurs  Fri

**After School Care** (3.30pm – 6.00pm) (Please tick appropriate box) Commencement Date: \_\_\_\_\_

Permanent Daily Basis  Permanent Days Circled  Casual Days & Emergencies   
(Please nominate days) Mon  Tue  Wed  Thurs  Fri

## **Before & After School Fee Agreement**

To ensure the Before & After School Program is financially viable families are required to pay **fees fortnightly**. Please complete the following fee agreement.

**Name and address of person responsible for Before & After School Fees.**

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

Home Address: \_\_\_\_\_

I \_\_\_\_\_ hereby agree to pay my Before & After School Care fees **fortnightly**. I understand that all outstanding fees must be paid for the first half of the term before my child/ren can return to the program in the second half of the term and all fees must be paid at the end of each term before children can attend the following term.

Parent's Name: \_\_\_\_\_ Parents Signature: \_\_\_\_\_

### **DECLARATION**

*Parents please read and initial each individual declaration statement.*

I/We have read the cancellation and booking procedures and agree to abide by the requirements and late penalties.

I/We understand it is my/our responsibility to inform the program if my/our child is not attending the program for a regular or casual booking.

I/We understand I must give the service one weeks' notice if I no longer require my child's Before & After School Care permanent booking.

I/We realise the program must be informed if my child is being collected by another person.

I/We agree to abide by the terms of the fee payment scheme and understand all outstanding before & After School Care Fees must be paid at the end of each term, before my child can return to the program the following term.

I/We realise that it is my/our responsibility to inform the program if my/our child contracts any illness, which could be detrimental to the health of others at the program.

I/We agree to collect or make arrangements for the collection of the child referred to in this enrolment form if she/he becomes unwell at the service.

I/We consent to the Coordinator or the person in charge to administer medication in emergency.

I/We authorise the person in charge, in the event of any illness or accident to obtain on my/our behalf any such medical assistance as my/our child may require and agree to meet any expenses.

Parent's Name: \_\_\_\_\_ Parents Signature: \_\_\_\_\_

Confidentiality of Enrolment Records *Ormond Primary Out of School Hours Program will ensure the information in this child's enrolment record will be not divulged to another person unless necessary for the care or education of the child, to manage medical treatment of the child, where expressly authorised by the parent or prescribed in the Children's Services Regulations 2009 (regulation 35(1) (d-e)*