Out Of School Hours Care

This information is confidential and will be available only to supervising staff

Family Details

Family Surname		Child's Name	

First Parent/Carer		**Second Parent/Carer**	
First Name		First Name	
Middle Name		Middle	
Surname		Surname	
Date Of Birth		Date Of Birth	
Address		Address	
Suburb		Suburb	
Postcode		Postcode	
Home Phone		Home Phone	
Mobile Phone		Mobile Phone	
Workplace		Workplace	
Work Phone		Work Phone	
Occupation		Occupation	
Medicare Number			
CRN Number		Family CRN	

Emergency Contacts

First Emergency Contact		**Second Emergency Contact**	
Name		Name	
Address		Address	
Home Phone		Home Phone	
Mobile Phone		Mobile Phone	
Relationship		Relationship	

Third Emergency Contact		**Fourth Emergency Contact**	
Name		Name	
Address		Address	
Home Phone		Home Phone	
Mobile Phone		Mobile Phone	
Relationship		Relationship	

Authorised Collectors

Name		Name	
Relationship		Relationship	
Phone		Phone	

Name		Name	
Relationship		Relationship	
Phone		Phone	

*Are there any **Family Court Orders**?	
☐ No	☐ Yes (Please attach a copy of the order)
*Are there any **Restraining Orders** in relation to the child/children?	
☐ No	☐ Yes (Please attach a copy of the order)

Child Details / Child Medical

Family Surname		Child's First Name	
Middle Name		Date Of Birth	
Country of Birth		Sex	
School		Languages at Home	
Class Teacher			
Doctor's Name		Clinic Name	
Address		Suburb	
Postcode		Phone	

* Does your child have a **health care need that could affect their safety at OSHC**?		
☐ No	☐ Yes	(If Yes please provide details below)

*Does your child have any **routine health care needs** (eg. **medication**)?
☐ No ☐ Yes (If Yes please provide details below)

*Are there any **special dietary requirements** relating to your child?		
☐ No	☐ Yes	(If Yes please provide details below)

*Does your child need **special aids or equipment**? (eg. Glasses, hearing aids, callipers)		
☐ No	☐ Yes	(If Yes please provide details below)

Health Care Plan

**Out of School Hours Care staff require a written health care plan from your child's doctor/ treating health professional to plan for any special health care needs.*
*Have you already provided the school with the required health plan?
☐ No (If No, please attach your child's health care form)
☐ Yes (If Yes, do you give permission for OSHC Staff to access this from the school?)
☐ No (If No, please attach your child's health care form)
☐ Yes

**All medication must be supplied in the original container with the pharmacy label and the child's name clearly marked on the container*

**A permission to administer medication form must be signed by the parent before medication can be administered by OSHC Staff*

Parent/Carer Signature	Date