St Leonards Primary School

Out of School Hours Care - Vacation Care - Family Enrolment Form

NAME OF PARENT/GUARDIAN CLAIMING FEE REDUCTION ***CRN Customer Reference Number Centrelink***

……D.O.B ……. C.R.N _ _ _ _ _ _ _ _ _ _ _

CHILD/REN'S NAME(S)	D.O.B	C.R.N
1…….…….	……	_ _ _ _ _ _ _ _ _ _ _
2…….…….	……	_ _ _ _ _ _ _ _ _ _ _
3…….…….	……	_ _ _ _ _ _ _ _ _ _ _
4…….……...	……	_ _ _ _ _ _ _ _ _ _ _
5…….……..	……	_ _ _ _ _ _ _ _ _ _ _

SCHOOL ATTENDED……..……

Number of children in any form of care……

PARENT/GUARDIAN (as above)

Name ……..

Address ……..

…….. Postcode ……..

Phone (H) …… (W) …….. (M) ……

Email (E) ……

Work Address ……

Country of Birth ……

Main Language at Home ……

OTHER PARENT/GUARDIAN Name……

Phone (H) …… (W) …… (M) ……..

Authority to collect: Yes / No **Emergency Contact: Yes / No**

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OTHER THAN PARENT/GUARDIAN People **AUTHORISED TO COLLECT** Children

IDENTIFICATION REQUIRED on collection

1 ……..…..… Relation to child/ren ……

2 …… Relation to child/ren ……

3 …… Relation to child/ren ……

EMERGENCY CONTACTS: **Other than parent/ guardian**

Name ……..…… Relationship to child ……

Address …… P/C ……...

Phone (H) …….. (W) …… (M) ……

Name …… Relationship to child ……

Address ……..P/C ……..

Phone (H) …….. (W) …… (M) ……

Is there any other information you feel would assist staff in caring for your child/ren?

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THE SERVICE MUST RECEIVE WRITTEN OR VERBAL PARENTAL/CARER CONSENT TO ALLOW CHILD/REN TO LEAVE THE PROGRAMME WITHOUT SUPERVISION

e.g. to walk home

Please turn over to complete further details

MEDICAL CONDITIONS *(e.g. Asthma, Allergies, Penicillin, Food, Other)*

Child's Name ……

Details, Treatment or Medication …….

……

Child's Name ……

Details, Treatment or Medication …….

Child's Name ……

Details, Treatment or Medication …….

In the event of my child receiving injuries requiring urgent medical treatment, I authorise the care providers and staff to obtain medical assistance, which they deem necessary, and agree to pay all medicals and transport costs incurred on behalf of my child.

I further authorise qualified practitioners to administer anaesthetic if the need arises:

Signature ……..

Medical Benefits ……..

Doctor's Name …… Ph ……..

Doctor's Address ……

IN THE EVENT OF ACCIDENT OR EMERGENCY, EVERY EFFORT WILL BE MADE TO CONTACT PARENTS PRIOR TO TAKING ACTION OR SEEKING TREATMENT

ANY OTHER INFORMATION ……..

……..…

CHILD/REN'S INTERESTS: ……..

……..

PARENTAL PERMISSION

- I give permission for my child to be transported by a staff member in a private car if deemed necessary by the Director.
- I give permission for photos of my child/ren to be taken and the names and/or photograph/s to be published in the school media or displayed at the service in circumstances which the Director considers appropriate.
- I understand that **in the event of unpaid accounts** the service will engage the service of a debt collector.

Parent/Carer Signature …… Date…….

INFORMATION IS TO RELATE TO ALL YOUR CHILDREN ENROLLED IN THIS PROGRAMME ***For Confidential census use only***

REASONS FOR CHILDREN ATTENDING:

Both Parents Working	❑	Single Parent Working	❑
One Parent Working & One Parent Studying	❑	Single Parent Studying	❑
One Parent Working & One Parent Looking for Work	❑	Single Parent Looking for Work	❑
Two Parents Looking for Work	❑	Respite Reasons	❑
Two Parents Studying	❑	Parent Disability	❑

Immunisations:

Tetanus	❑	Measles	❑
Diphtheria	❑	Polio	❑
Whooping Cough	❑	Mumps	❑
No Immunisation	❑		

***Do any of your children have additional needs*:** (If yes, please complete the following)

Sensory	❑	Gifted	❑
Physical	❑	Medical Condition	❑
Speech and Language	❑	Syndrome	❑
Emotional	❑	Disability	❑
Special Needs Family	❑	Multiple Disability	❑

Culture: Aboriginal Descent ❑ Torres Strait Islander ❑

Other ❑ please specify _ _ _ _ _ _ _ _ _ _