OUTSIDE SCHOOL HOURS CARE PROGRAM
ENROLMENT FORM

Rowellyn Park PRIMARY SCHOOL
together we learn

This form is to be completed if you would like your children to be enrolled at this service.
The information requested is to assist the service in providing excellent care for your children. A parent or guardian who has lawful authority in relation to the child must complete this form. A brief explanation of lawful authority is found at the end of this form. Licensed children's services may use this form to collect the child's enrolment information as required in regulations 31 to 35.*Questions marked with an asterisk * are not required by the Regulations, but you are encouraged to answer these to assist the service in caring for your child.* The answers provided are strictly confidential and will not be used for any other purpose. Thank you.

Service Philosophy:
At Rowellyn Park OSHC we provide the community with a quality primary school-aged childcare service, before and after school and during school holidays. Our inclusive environment enables children to have a sense of belonging. Guided by the National Quality Standards including the use of Early Years Framework and other approved Frameworks (My Time Our Place-OSHC) our educators will collaborate with families, children and other professionals to provide a program based on an approved learning framework to achieve common outcomes for all children. This includes their safe care, sound physical health, development needs, interests and experiences of each child and takes into account the individual differences of each child.

Information about the child's parents or guardians

Mother	**Father**
First Name:	First Name:
Surname:	Surname:
Date of birth:	Date of birth:
CRN No:	CRN No:
Address:	Address:
Email address:	Email address:
Telephone: (H) Mobile:	Telephone: (H) Mobile:
Workplace:	Workplace:
Work Phone:	Work Phone:
Occupation:	Occupation:
Does the child live with this guardian? Yes ❑ No ❑ (please tick)	Does the child live with this guardian? Yes ❑ No ❑ (please tick)
Language spoken at home: Cultural background:	Language spoken at home: Cultural back ground:
Medicare no:..... Health Care Card no:..... Ambulance no:	Medicare no:..... Health Care Card no:..... Ambulance no:.....

Guardian (if applicable)	**Guardian** (if applicable
First Name:	First Name:
Surname:	Surname:
Date of birth:	Date of birth:
CRN No:	CRN No:
Address:	Address:

Email address:	Email address:
Telephone: (H) Mobile:	Telephone: (H) Mobile:
Workplace:	Workplace:
Work Phone:	Work Phone:
Occupation:	Occupation:
Does the child live with this guardian? Yes ❑ No ❑ (please tick)	Does the child live with this guardian? Yes ❑ No ❑ (please tick)
Language spoken at home: Cultural background:	Language spoken at home: Cultural background:
Medicare no:..... Health Care Card no:..... Ambulance no:	Medicare no:..... Health Care Card no:..... Ambulance no:.....

Please note only need the CRN no and date of birth of parent or guardian who receives tax benefit (who will claim CCMS)

Authorised nominee:

There may be times when the child has an accident, injury, trauma or illness and the parents or guardians cannot be contacted. To deal with these situations the children's service should notify one of the following people who are authorised to collect and care for the child after accident, injury, trauma or illness.

❑ Any person who is authorised to consent to medical treatment of, or to authorise administration of medication to, the child.

❑ Any person who is authorised to authorise and educator to take the child outside the education and care service premises;

❑ An authorisation, signed by a parent or a person named in the enrolment record as authorised to consent to the medical treatment of the child, for the family day care educator to seek-

(i) Medical treatment for the child from a registered medical practitioner, hospital or ambulance service; and

(ii) Transportation of the child by an ambulance service; and

If relevant, an authorisation given under regulation 102 for the family day care educator to take the child on regular outings.

First Name:	First Name:
Surname:	Surname:
Address:	Address:
Telephone (H) Mobile:	Telephone (H) Mobile:
Relationship to child:	Relationship to child:

Court orders relating to the child

Are there any **court orders, parenting orders or parenting plans** relating to the powers, duties, responsibilities or authorities of any person in relation to the child or access to the child?

❑ No⟶ go to the next section. ⟶

❑ Yes ❑ Copy enclosed ❑ Copy kept on file at school office

P**lease complete the following:**

1. Bring the **original** court order/s for staff to see and a copy to attach to this enrolment form;
2. If these orders:
   a) change the powers of a parent/guardian to:
      - authorise the taking of the child outside the service by a staff member of the service;
      - in the case of a family day care service, the taking of the child outside the family day career's
      - residence or family day care venue by a family day carer,
      - consent to the medical treatment of the child;
      - request or permit the administration of medication to the child;
      - collect the child from the service or family day care, AND/OR

   b) give these powers to someone else

   then describe these changes and provide the contact details of any person given these powers below:

.....

.....

Details of people who you authorise to collect your child.

Your consent is required for other people to collect the child from the children's service on your behalf. In the table below please list the details of those people you have authorised to collect the child This list may be added to or changed throughout the year. In the event that the child is not collected from the children's service and the parents or guardians cannot be contacted, this list will also be used to arrange someone to collect the child.

First Name:	First Name:
Surname:	Surname:
Address:	Address:
Telephone (H) Mobile:	Telephone (H) Mobile:
Relationship to child:	Relationship to child:

First Name:	First Name:
Surname:	Surname:
Address:	Address:
Telephone (H) Mobile:	Telephone (H) Mobile:
Relationship to child:	Relationship to child:

First Name:	First Name:
Surname:	Surname:
Address:	Address:
Telephone (H) Mobile:	Telephone (H) Mobile:
Relationship to child:	Relationship to child:

Information about the child **(1)**

Family Name: …… Date of Birth: …….. Sex: M❑ F❑ (please tick)

Given Name: ……..……. Usually called ……..

CRN no: ……. Language spoken in the home: ……..……....

Cultural background: ……

Address: ……..

*Is the child of Aboriginal and/or Torres Strait Islander origin? (please tick)

❑ No, not Aboriginal or Torres Strait Islander ❑ Yes, Aboriginal

❑ Yes, Aboriginal and Torres Strait Islander ❑ Yes, Torres Strait Islander

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

Child's health information

Name Doctor/Medical Service:..... Telephone:.....

Address Doctor/Medical Service:.....

Medicare No:..... *Maternal & Child Health (MCH) Centre:.....

Does your child have a child health record? No ❑ Yes ❑ (please tick) **If yes**, please provide to the service for sighting.
Child health record means a record that documents a child's health and development assessments and immunisations.
Name and position of person at the children's service who has sighted the child's health record.

Name:..... Position:.....

Child's medical information

Does your child have any special needs? No ❑ Yes ❑ (please tick)
If yes please provide details of any special needs and any management procedure to be followed with respect to the special need.
.....
.....
.....
Does your child have any other medical conditions? (eg asthma, epilepsy, diabetes, dizzy spells heart condition etc that are relevant to the care of your child) No ❑ Yes ❑(please tick)
If yes please provide details of any medical condition and any management procedure to be followed with respect to the medical condition.

Asthma
No ❑ Yes ❑ (please tick)
If yes please provide a management plan and procedure signed by a doctor.
.....
.....
.....
Diabetes
Does your child have any special needs? No ❑ Yes ❑ (please tick)
If yes please provide details of any special needs and any management procedure to be followed with respect to the special need.
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.....

Allergies

Does your child have any allergies or sensitivity? (please tick) No ❑ Yes ❑
Penicillin ❑ Aspirin ❑ Bandaids ❑ Bee Stings ❑
Any food (please list food)❑.....

If yes please provide details of any allergies and any management procedure to be followed with respect to the allergy. (Please note if there is an allergy you will need to provide an allergy plan signed by a doctor before the child can commence care).
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.....

Anaphylaxis

Has your child been diagnosed at risk of anaphylaxis? No❑ Yes ❑
Does your child have an auto injection device (eg EpiPen®)? No❑ Yes ❑
Has the anaphylaxis medical management plan been provided to the service? No❑ Yes ❑
Has a risk management plan been completed by the service in consultation with you? No❑ Yes ❑

In the case of anaphylaxis you will by provided with a copy of the services anaphylaxis management policy. You will be required to provide the service with an individual medical management plan for your child signed by the medical practitioner who is treating your child. This will be attached to your child's enrolment form. More information is available at www.education.vic.gov.au/anaphylaxis

Does your child have any other medical conditions? (eg asthma, epilepsy, diabetes, dizzy spells heart condition etc that are relevant to the care of your child) No ❑ Yes ❑(please tick)
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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Does the child have any dietary restrictions? No ❑ Yes ❑ (please tick)
If yes, the following restrictions apply:
…….
……..

Permission:

To use:

Sunscreen ☐ Zinc Cream ☐ Hair spray ☐ Face Paint ☐

Photo's display at OSHC only ☐ Photo's (local paper/display) ☐ Head Lice Checks ☐

Child's immunisation record

Has the child been immunised? No☐ Yes☐ (please tick)
Has been sighted by the Coordinator No ☐ Yes ☐ (please tick)
Name: _____ Sign:_____ of person who has sighted the immunisation record.

***If yes**, provide the details by:

- attaching a copy of the Immunisation Record from the Child Health Record book OR
- attaching a copy of the Immunisation Record printout from local government OR
- attaching the Child History Statement from the Australian Childhood Immunisation Register OR
- completing the table below using the child's Immunisation Record to provide the dates of immunisations received.

Immunisation (valid from March 2008)	**Birth**	**2 months**	**4 months**	**6 months**	**12 months**	**18 months**	**4 years**
Hepatitis B							
Diphtheria, tetanus and acellular pertussis (DTPa)							
Haemophilus influenza (Type b)							
Inactivated poliomyelitis (IPV)							
Pneumococcal conjugate (7vPCV)							
Rotavirus							
Measles, mumps and rubella (MMR)							
Meningococcal C							
Varicella (VZC)							

Additional immunisations for Aboriginal and Torres Strait Islander children (if required)

	12-24 months		**18-24 months**
Hepatitis A			
Pneumococcal polysaccharide (23vPPV)			

Other information

If there is anything else that the children's service should know about the child? (eg excessive fears, favourite activities, attending other early childhood service or early intervention service, etc)

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Information about the child (2)

Family Name: …… Date of Birth: …….. Sex: M❑ F❑ (please tick)

Given Name: ……..……. Usually called ……..

CRN no: ……. Language spoken in the home: ……..……....

Cultural background:……..

Address: ……..

*Is the child of Aboriginal and/or Torres Strait Islander origin? (please tick)

❑ No, not Aboriginal or Torres Strait Islander ❑ Yes, Aboriginal
❑ Yes, Aboriginal and Torres Strait Islander ❑ Yes, Torres Strait Islander

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

Child's health information

Name Doctor/Medical Service:..... Telephone:.....

Address Doctor/Medical Service:.....

Medicare No:..... *Maternal & Child Health (MCH) Centre:.....

Does your child have a child health record? No ❑ Yes ❑ (please tick) **If yes**, please provide to the service for sighting.
Child health record means a record that documents a child's health and development assessments and immunisations.
Name and position of person at the children's service who has sighted the child's health record.

Name:..... Position:.....

Child's medical information

Does your child have any special needs? No ❑ Yes ❑ (please tick)
If yes please provide details of any special needs and any management procedure to be followed with respect to the special need.
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Does your child have any allergies or sensitivity? (please tick) No ❑ Yes ❑ Penicillin ❑ Aspirin ❑
Bandaids ❑ Bee Stings ❑ Any food (please list food)❑.....

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

Has your child been diagnosed at risk of anaphylaxis?	No❑	Yes ❑
Does your child have an auto injection device (eg EpiPen®)?	No❑	Yes ❑
Has the anaphylaxis medical management plan been provided to the service?	No❑	Yes ❑
Has a risk management plan been completed by the service in consultation with you?	No❑	Yes ❑

In the case of anaphylaxis you will by provided with a copy of the services anaphylaxis management policy. You will be required to provide the service with an individual medical management plan for your child signed by the medical practitioner who is treating your child. This will be attached to your child's enrolment form. More information is available at www.education.vic.gov.au/anaphylaxis

Does your child have any other medical conditions? (eg asthma, epilepsy, diabetes, dizzy spells heart condition etc that are relevant to the care of your child) No ❑ Yes ❑(please tick)
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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Does the child have any dietary restrictions? No ❑ Yes ❑ (please tick)
If yes, the following restrictions apply:
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……

Permission:

To use:

Sunscreen ❑ Zinc Cream ❑ Hair spray ❑ Face Paint ❑

Photo's display at OSHC only ❑ Photo's (local paper/display) ❑ Head Lice Checks ❑

Child's immunisation record

Has the child been immunised? No ❑ Yes ❑ (please tick)
Has been sighted by the Coordinator No ❑ Yes❑ (please tick) Name: _____
Sign:_____ of person who has sighted the immunisation record.

***If yes**, provide the details by:

- attaching a copy of the Immunisation Record from the Child Health Record book OR

- attaching a copy of the Immunisation Record printout from local government OR
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- completing the table below using the child's Immunisation Record to provide the dates of immunisations received.

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Hepatitis B							
Diphtheria, tetanus and acellular pertussis (DTPa)							
Haemophilus influenza (Type b)							
Inactivated poliomyelitis (IPV)							
Pneumococcal conjugate (7vPCV)							
Rotavirus							
Measles, mumps and rubella (MMR)							
Meningococcal C							
Varicella (VZC)							

Additional immunisations for Aboriginal and Torres Strait Islander children (if required)

	12-24 months		**18-24 months**
Hepatitis A			
Pneumococcal polysaccharide (23vPPV)			

Other information

If there is anything else that the children's service should know about the child? (eg excessive fears, favourite activities, attending other early childhood service or early intervention service, etc)

……

……

……

Information about the child (3)

Family Name: …… Date of Birth: …….. Sex: M❑ F❑ (please tick)

Given Name: ……..……. Usually called ……..

CRN no: …….. Language spoken in the home: ……..……....

Cultural background:……..

Address: ……..

*Is the child of Aboriginal and/or Torres Strait Islander origin? (please tick)

❑ No, not Aboriginal or Torres Strait Islander ❑ Yes, Aboriginal

❑ Yes, Aboriginal and Torres Strait Islander ❑ Yes, Torres Strait Islander

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

Child's health information

Name Doctor/Medical Service:..... Telephone:.....

Address Doctor/Medical Service:.....

Medicare No:..... *Maternal & Child Health (MCH) Centre:.....

Does your child have a child health record? No ❑ Yes ❑ (please tick) **If yes**, please provide to the service for sighting.
Child health record means a record that documents a child's health and development assessments and immunisations.
Name and position of person at the children's service who has sighted the child's health record.

Name:..... Position:.....

Child's medical information

Does your child have any special needs? No ❑ Yes ❑ (please tick)
If yes please provide details of any special needs and any management procedure to be followed with respect to the special need.
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Does your child have any allergies or sensitivity? (please tick) No ❑ Yes ❑ Penicillin ❑ Aspirin ❑
Bandaids ❑ Bee Stings ❑ Any food (please list food)❑.....

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

Anaphylaxis

Has your child been diagnosed at risk of anaphylaxis?	No❑	Yes ❑
Does your child have an auto injection device (eg EpiPen®)?	No❑	Yes ❑
Has the anaphylaxis medical management plan been provided to the service?	No❑	Yes ❑
Has a risk management plan been completed by the service in consultation with you?	No❑	Yes ❑

In the case of anaphylaxis you will by provided with a copy of the services anaphylaxis management policy. You will be required to provide the service with an individual medical management plan for your child signed by the medical practitioner who is treating your child. This will be attached to your child's enrolment form. More information is available at www.education.vic.gov.au/anaphylaxis

Does your child have any other medical conditions? (eg asthma, epilepsy, diabetes, dizzy spells heart condition etc that are relevant to the care of your child) No ❑ Yes ❑(please tick)
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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.....

Does the child have any dietary restrictions? No ❑ Yes ❑ (please tick)
If yes, the following restrictions apply:
……..
……..

Permission:

To use:
Sunscreen ☐ Zinc Cream ☐ Hair spray ☐ Face Paint ☐
Photo's display at OSHC only ☐ Photo's (local paper/display) ☐ Head Lice Checks ☐

Child's immunisation record

Has the child been immunised? No ❑ Yes ❑ (please tick)
Has been sighted by the Coordinator No ☐ Yes ☐ (please tick) Name: _____
Sign:_____ of person who has sighted the immunisation record.

***If yes**, provide the details by:

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Haemophilus influenza (Type b)							
Inactivated poliomyelitis (IPV)							
Pneumococcal conjugate (7vPCV)							
Rotavirus							
Measles, mumps and rubella (MMR)							
Meningococcal C							

Varicella (VZC)							

Additional immunisations for Aboriginal and Torres Strait Islander children (if required)

	12-24 months		18-24 months
Hepatitis A			
Pneumococcal polysaccharide (23vPPV)			

Other information

If there is anything else that the children's service should know about the child? (eg excessive fears, favourite activities, attending other early childhood service or early intervention service, etc)

……

……

……

Information about the child (4)

Family Name: …… Date of Birth: …….. Sex: M❑ F❑ (please tick)

Given Name: ……..……. Usually called ……..

CRN no: ……. Language spoken in the home: ……..……...

Cultural background:……..

Address: ……..

*Is the child of Aboriginal and/or Torres Strait Islander origin? (please tick)

❑ No, not Aboriginal or Torres Strait Islander ❑ Yes, Aboriginal

❑ Yes, Aboriginal and Torres Strait Islander ❑ Yes, Torres Strait Islander

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

Child's health information

Name Doctor/Medical Service:..... Telephone:.....

Address Doctor/Medical Service:.....

Medicare No:..... *Maternal & Child Health (MCH) Centre:.....

Does your child have a child health record? No ❑ Yes ❑ (please tick) **If yes**, please provide to the service for sighting.
Child health record means a record that documents a child's health and development assessments and immunisations.
Name and position of person at the children's service who has sighted the child's health record.

Name:..... Position:.....

Child's medical information

Does your child have any special needs? No ❑ Yes ❑ (please tick)
If yes please provide details of any special needs and any management procedure to be followed with respect to the special need.

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Does your child have any allergies or sensitivity? (please tick) No ❑ Yes ❑ Penicillin ❑ Aspirin ❑
Bandaids ❑ Bee Stings ❑ Any food (please list food)❑.....

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

.....
.....

Anaphylaxis

Has your child been diagnosed at risk of anaphylaxis? No❑ Yes ❑
Does your child have an auto injection device (eg EpiPen®)? No❑ Yes ❑
Has the anaphylaxis medical management plan been provided to the service? No❑ Yes ❑
Has a risk management plan been completed by the service in consultation with you? No❑ Yes ❑

In the case of anaphylaxis you will by provided with a copy of the services anaphylaxis management policy. You will be required to provide the service with an individual medical management plan for your child signed by the medical practitioner who is treating your child. This will be attached to your child's enrolment form. More information is available at www.education.vic.gov.au/anaphylaxis

Does your child have any other medical conditions? (eg asthma, epilepsy, diabetes, dizzy spells heart condition etc that are relevant to the care of your child) No ❑ Yes ❑(please tick)
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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Does the child have any dietary restrictions? No ❑ Yes ❑ (please tick)
If yes, the following restrictions apply:
……..
……..

Permission:

To use:
Sunscreen ☐ Zinc Cream ☐ Hair spray ☐ Face Paint ☐
Photo's display at OSHC only ☐ Photo's (local paper/display) ☐ Head Lice Checks ☐

Child's immunisation record

Has the child been immunised? No ❑ Yes ❑ (please tick)
Has been sighted by the Coordinator No ☐ Yes ☐ (please tick) Name: _____
Sign:_____ of person who has sighted the immunisation record.

***If yes**, provide the details by:

- attaching a copy of the Immunisation Record from the Child Health Record book OR
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Haemophilus influenza (Type b)							
Inactivated poliomyelitis (IPV)							
Pneumococcal conjugate (7vPCV)							
Rotavirus							
Measles, mumps and rubella (MMR)							
Meningococcal C							
Varicella (VZC)							

Additional immunisations for Aboriginal and Torres Strait Islander children (if required)

	12-24 months		**18-24 months**
Hepatitis A			
Pneumococcal polysaccharide (23vPPV)			

****Other information***

If there is anything else that the children's service should know about the child? (eg excessive fears, favourite activities, attending other early childhood service or early intervention service, etc)
……

……

ENROLMENT DETAILS

HOURS TO ATTEND CENTRE

Opening Hours

- **Before Care 6.30am-8.45am** **Pupil Free Day 6.30am-6.30pm**
- **After Care 3.15pm-6.45pm** **Vacation Care 6.30am-6.30pm**

Requested date to start care _____

Type of care required: Before ❑ After ❑ Vacation/Pupil Free ❑ (forms will be sent)

	Monday	Tuesday	Wednesday	Thursday	Friday
Before care (am)	❑	❑	❑	❑	❑
After care (pm)	❑	❑	❑	❑	❑

Do you have siblings attending other funded care yes ❑ no ❑

If yes how many? _____
(please do not include the children attending this care)

Declaration and consent to emergency medical treatment

I, *(Print full name)*_____

- declare that the information in this enrolment form is true and correct and undertake to immediately inform the children's service in the event of any change to this information;
- agree to collect or make arrangements for the collection of the child referred to in this enrolment form if s/he becomes unwell at the service;
- consent to the approved provider or in the case of an OSHC, the OSHC service to seek medical treatment for the child from a medical practitioner, hospital or ambulance service.

Signature…… Date……..

Confidentiality of enrolment records

The proprietor of the children's service must ensure that information in the child's enrolment record is 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' Services Regulations 2009 (regulation 35(1) (d-e)
Parenting order means a parenting order within the meaning of section 64B (1) of the Family Law Act 1975 of the Commonwealth;
Parenting plan means a parenting plan within the meaning of section 63C (1) of the Family Law Act 1975 of the Commonwealth, and includes a registered parenting plan within the meaning of section 63C(6) of that Act.

Approved providers are reminded of their requirement to comply with the Information Privacy Act 2000, which requires a Privacy Collection Statement to accompany any enrolment form

We would like your input of what your expectations of the program are for your child. This information is used to meet your child's needs, interests and for future planning.

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_____

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