



Upper Ferntree Gully Primary School Out of School Hours Care

<b>Enrolment Details</b>	<b>Enrolment Date</b>
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A parent or guardian who has lawful authority in relation to this child must complete this form. A brief explanation of this 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.

**CHILDS INFORMATION**

**Family Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Sex:** Male/Female (please circle)

**Given Names:** \_\_\_\_\_ **\*Usually Called:** \_\_\_\_\_

**Childs CRN:** \_\_\_\_\_ **Grade** \_\_\_\_\_

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

**Language(s) spoken in the home:** \_\_\_\_\_

**Religion:** \_\_\_\_\_

**\*Is the child Aboriginal and/or Torres Strait Islander origin?**

YES/NO (please circle one)

**\*Does the child have a developmental delay or disability including intellectual, sensory or physical impairment?**

YES/NO (please circle one)

**Information about the child’s parents or Guardians**

<b>Mother / Guardian</b> (please circle)	<b>Father / Guardian</b> (please circle)
Name	Name
Address	Address
CRN	CRN
Date of Birth	Date of Birth
Telephone/s (H) (W) (Mobile)	Telephone/s (H) (W) (Mobile)
<b>Email address</b>	<b>Email address</b>
Occupation	Occupation
Work address	Work Address

**Account Detail** - invoice to be sent to: (please circle one)

Parent / Guardian 1 \_\_\_\_\_ Parent/Guardian 2 \_\_\_\_\_

I agree to meet any invoiced costs incurred by my child attending the program and pay them by the due date.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE TICK THE DAYS/SESSIONS YOUR CHILD WILL BE ATTENDING THE PROGRAM**

	Monday		Tuesday		Wednesday		Thursday		Friday	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Permanent										
Casual										

**Court orders relating to the child**

Are there any **Court Orders** relating to the powers, duties, responsibilities or authorities of any person in relation to the child or access to the child? (Please Circle)

NO Go to the next section Yes please complete the following

1. Bring the **original** court order/s for staff to see and a copy to attach to the enrolment form.
2. If these orders:
  - a. Change the powers of the parent/guardian to:
    - i. Authorise the taking of the outside the service by a staff member of the service.
    - ii. Consent to medical treatment of the child.
    - iii. Request or permit the administration of medication to the child.
    - iv. Collect the child from the service
  - b. Give these powers to someone else.

**Please describe these changes and provide the contact details of any person given these powers:**

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**OTHER PERSONS TO BE NOTIFIED**

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.

Name	Name
Address	Address
Telephone/s (H) (W)	Telephone/s (H) (W)

(Mobile)	(Mobile)
Relationship to child:	Relationship to child:

**Please complete 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 the people you have authorised to collect your child. The 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.

Name	Name
Address	Address
Telephone/s (H) (W) (Mobile)	Telephone/s (H) (W) (Mobile)
Relationship to child:	Relationship to child:
Name	Name
Address	Address
Telephone/s (H) (W) (Mobile)	Telephone/s (H) (W) (Mobile)
Relationship to child:	Relationship to child:
Name	Name
Address	Address
Telephone/s (H) (W) (Mobile)	Telephone/s (H) (W) (Mobile)
Relationship to child:	Relationship to child:

**Child's health information**

Name of Doctor \_\_\_\_\_ Telephone \_\_\_\_\_

Medical Centre/Address \_\_\_\_\_  
\_\_\_\_\_

Medicare number \_\_\_\_\_ Healthcare Card \_\_\_\_\_

Ambulance subscription YES / NO Membership Number \_\_\_\_\_

Private Health Insurance YES / NO FUND \_\_\_\_\_ Membership No. \_\_\_\_\_

**Child's medical information**

Does your child have any special needs? YES/NO (Please circle)

**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 medical issues, allergies or dietary requirements?  
YES / NO (please circle)

**If yes** please provide details of any allergies or dietary requirements and any management procedures to be followed.

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

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**Anaphylaxis** (Please circle)

Has your child been diagnosed at risk of anaphylaxis? Yes / No

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

Has the anaphylaxis medical management plan been provided to the service? Yes / No

Has a risk management plan been completed by the service in consultation with you? Yes/ No

In the case of anaphylaxis you will be provided with a copy of the service 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](http://www.education.vic.gov.au/anaphylaxis)

Does your child have any other medical conditions? (e.g. asthma, epilepsy, diabetes etc. that are relevant to the care of your child)

Yes / No (please circle)

**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 requirements/restrictions?

Yes / No (please circle)

**If yes** please note what restrictions apply.

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### Childs immunisation record

Has the child been immunised?

Yes / No (Please circle) (Please provide evidence for OSHC staff)

### Other information

If there is anything else that the children's service should know about the child? (e.g. excessive fears, favourite activities, have attended other services or any other issues relating to the child (e.g. behavioural issues, triggers, family issues.)

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### Declaration and consent to emergency medical treatment

I \_\_\_\_\_ (Please print full name)

a person with lawful authority of the child referred to in this enrolment form.

- 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 she/he becomes unwell at the service:
- Consent to the programs Coordinator/ Assistant to seek medical treatment for the child from a medical practitioner, hospital or ambulance and agree to meet any expenses attached to such treatment.
- I acknowledge that my child will not attend the program if suffering from an infectious or contagious disease.

Signature \_\_\_\_\_ Date \_\_\_\_\_

