St Joseph’s School, Tranmere Out of School Hours Care

APPLICATION FOR ENROLMENT

1 Birkinshaw Avenue Tranmere SA 5073
Phone 8431 2834 / Fax 8431 2022
Email: mheaney@stjotran.catholic.edu.au
Website: www.stjotran.catholic.edu.au
OUT OF SCHOOL HOURS CARE
SESSION TIMES

Before School Care
Full Session  7.30 – 8.20am
Part Session  8.00 – 8.20am

After School Care
Full Session  3.15 – 6.00pm
Part Session  3.15 – 4.30pm

Bookings can be made by contacting:
The OSHC service in person,
emailing: mheaney@stjotran.catholic.edu.au,
telephoning: 0419 831 298 - please leave a message on the
answering service if we are unavailable.
OR alternatively
at the School Office either in person or by telephone.
Ph. 8431 2834

Bookings are essential for the care of students

DAYS REQUIRING CARE
Date to start Out of School Hours Care: ___________________________
Type of care required:  Permanent ☐ (days stay the same each week)  Casual ☐ (changes from week to week)

<table>
<thead>
<tr>
<th></th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
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<tbody>
<tr>
<td>BSC</td>
<td>Part</td>
<td>Full</td>
<td>Part</td>
<td>Full</td>
<td>Part</td>
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<tr>
<td>ASC</td>
<td>Part</td>
<td>Full</td>
<td>Part</td>
<td>Full</td>
<td>Part</td>
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</tbody>
</table>

Please circle the sessions you require (a part session concludes at 4.30pm)

If your child has a serious medical condition or allergy, it will be necessary to arrange a
meeting with the OSHC Director.

Please tick if you require an interview ☐

Office Use
Date held:

Parent/Guardian attending:
CHILD DETAILS
Family Name: ____________________________ Given Name(s): ____________________________
Birth date: __/__/____ Male / Female (Please circle) CCB CRN: __________________________
School: _______________________________________ Yr level: ____________

CHILD PROFILE
Foods they like: _________________________________________________________________
What sporting activities and/or other activities or hobbies does your child enjoy? Eg: Lego, craft, soccer etc. _________________________________________________________________
What values and attitudes would you like your child to have/learn: e.g. sharing, respect for others, etc. _________________________________________________________________

MEDICAL HEALTH INFORMATION
Has your child been fully immunised? Yes No Fully immunised against Tetanus? Yes No
Date of last immunisation __/__/____ If no, please give details: __________________________
I accept full responsibility if my child is not immunised. Parent/guardian signature: ______________________
Does your child have a medical condition/take medication that may be effected by OSHC activities? Yes No
If yes, please give details and any related medication: ______________________________________________
Does your child have any special needs? Yes No
If yes, please be specific and give details and any related medication (eg. Asthma – Ventolin).

Does your child require special aids (eg. Glasses, hearing aid etc.)? Yes No
If yes, please give details: _________________________________________________________________
Is there any other medical information we need to know? _______________________________________

Please supply the required medications in original containers with child’s name clearly marked together with the Medication Plan provided by doctor. Please complete permission to administer medication form together with any medication records where necessary.

DIETARY REQUIREMENTS
Does your child have any special dietary needs not related to allergies? Yes No
If yes, please give details: _________________________________________________________________
Does your child have any allergic reactions to - Food /Medication ie; Penicillin please be specific Yes No

Are there any Dietary Requirements that we should be aware of? ____________________________________
CHILD DETAILS

Family Name: _____________________________  Given Name(s): _____________________________

Birth date: ____/____/_____  Male / Female (Please circle)  CCB CRN: _____________________________

School: __________________________________________________________  Yr level: ____________

CHILD PROFILE

Foods they like: _____________________________________________________________________________

What sporting activities and/or other activities or hobbies does your child enjoy? Eg: Lego, craft, soccer etc.
_________________________________________________________________________________________

What values and attitudes would you like your child to have/learn: e.g. sharing, respect for others, etc.
_________________________________________________________________________________________

MEDICAL HEALTH INFORMATION

Has your child been fully immunised?  Yes [ ]  No [ ]  Fully immunised against Tetanus?  Yes [ ]  No [ ]

Date of last immunisation ____/____/____  If no, please give details: _____________________________

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Does your child have a medical condition/take medication that may be effected by OSHC activities? Yes [ ]  No [ ]

If yes, please give details and any related medication: _____________________________________________

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_________________________________________________________________________________________

Does your child require special aids (eg. Glasses, hearing aid etc.)?  Yes [ ]  No [ ]

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School: ____________________________________  Yr level:____________________

CHILD PROFILE

Foods they like: _____________________________________________________________________________

What sporting activities and/or other activities or hobbies does your child enjoy? Eg: Lego, craft, soccer etc.
_________________________________________________________________________________________

What values and attitudes would you like your child to have/learn: e.g. sharing, respect for others, etc.
_________________________________________________________________________________________

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Fully immunised against Tetanus? Yes ☐  No ☐

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_________________________________________________________________________________________
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Birth date: ____/____/____  Male / Female (Please circle)  CCB CRN: ____________________________

School: __________________________________________________________  Yr level: __________

**CHILD PROFILE**

Foods they like: __________________________________________________________

What sporting activities and/or other activities or hobbies does your child enjoy? Eg: Lego, craft, soccer etc.

________________________________________________________________________

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________________________________________________________________________

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_________________________________________________________________________________________

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Does your child have any allergic reactions to - Food /Medication ie; Penicillin  please be specific  Yes ☐  No ☐

_________________________________________________________________________________________

Are there any Dietary Requirements that we should be aware of?  ______________________________________

_________________________________________________________________________________________
PARENT / GUARDIAN AND BILLING DETAILS

Language spoken at home: ______________________ Other language: ______________________
Cultural background: ______________________ Religion: ______________________

What is the reason for your child’s attendance at St Joseph’s School Tranmere OSHC?

☐ Single parent studying/working  ☐ At risk/referral  ☐ one parent working / one studying

☐ Child Disability  ☐ Respite Purposes  ☐ Both parents studying/working

☐ Parents seeking work  ☐ Parent  ☐ Disability

<table>
<thead>
<tr>
<th>Enrolling Parent/Guardian 1</th>
<th>Parent/Guardian 2</th>
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<tbody>
<tr>
<td><strong>Title:</strong> Mr Mrs Ms Miss Dr (please circle)</td>
<td>Mr Mrs Ms Miss Dr (please circle)</td>
</tr>
<tr>
<td><strong>Family Name:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Given Name(s):</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Occupation:</strong></td>
<td></td>
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<tr>
<td><strong>Date of Birth:</strong></td>
<td>CRN:</td>
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<tr>
<td><strong>Residential Address:</strong></td>
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<td></td>
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<td><strong>Postal Address:</strong></td>
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<td>(mark ‘same as’ above if not different)</td>
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<tr>
<td><strong>Telephone Numbers:</strong> Home:</td>
<td>Home:</td>
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<tr>
<td>Work: Mobile:</td>
<td>Work: Mobile:</td>
</tr>
<tr>
<td><strong>Relationship to child:</strong></td>
<td>(Father, Mother, Foster Parent etc)</td>
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<tr>
<td><strong>Contact priority:</strong></td>
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<tr>
<td><strong>Email Address:</strong></td>
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Do you wish to receive your account via email? YES ☐ NO ☐

Child resides with:  ☐ mother  ☐ father  ☐ both parents  ☐ guardian: ______________________

Family Court or other relevant Court Order (please tick): YES ☐ NO ☐

(If yes, OSHC must be given a current copy of that order)

AUTHORITY TO COLLECT AND EMERGENCY CONTACT

<table>
<thead>
<tr>
<th>Contact 1</th>
<th>Contact 2</th>
<th>Contact 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong></td>
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<td><strong>Mobile:</strong></td>
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<td><strong>Work:</strong></td>
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<td><strong>Home:</strong></td>
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<tr>
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</tbody>
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MEDICAL ATTENTION IN CASE OF ACCIDENT OR EMERGENCY

In case of accident /emergency, every effort will be made to contact parent/s. In the event of my child receiving injuries requiring urgent medical treatment I authorise the OSHC staff to obtain medical assistance that they deem necessary and I agree to pay all medical and transport costs incurred on behalf of my child. Yes ☐ No ☐

Full Name: _______________________________ Signature: _______________________________

Full Name: _______________________________ Signature: _______________________________

Doctor’s name: _______________________________ Phone: _______________________________

Address: _______________________________ Post Code: _______________________________

Medical Benefit cover with: _______________________________ Medicare Number: _______________________________

Ambulance cover with: _______________________________ Health Care Card Number: _______________________________

CONSENTS

I give consent for my child to:(please tick)

• be photographed and their image published where the director deems it appropriate. Yes ☐ No ☐

• have sun block applied by a staff member if required. Yes ☐ No ☐

• have insect repellent applied to my child if required. Yes ☐ No ☐

• be taken by a staff member to the local hospital or doctor’s surgery in the event of an injury. Yes ☐ No ☐

• go barefoot when the OSHC staff see this as reasonable. Yes ☐ No ☐

• to watch G and PG rated movies at the discretion of the OSHC staff Yes ☐ No ☐

Signature: _______________________________ Date: _______________________________

AGREEMENT

I agree to pay the required fees for my child’s OSHC care. Yes ☐ No ☐

I accept the policies and rules of the service. Yes ☐ No ☐

I agree that the staff of the service may administer simple first aid if the need arises. Yes ☐ No ☐

I understand that it my responsibility to set up and maintain all Centrelink information and to make sure that everything is correct and set in place. Yes ☐ No ☐

I certify that the information entered in this form is true to the best of my knowledge and I undertake to inform the service if any of these details change. Yes ☐ No ☐

Signature: _______________________________ Date: _______________________________

ANNUAL OSHC ENROLMENT FEE

All families that use the St Joseph’s School Tranmere OSHC program will be charged a flat enrolment fee of $10.00 per child. This fee will be charged on an annual basis and covers the cost of the supply of a hat, sunscreen and the administration of the service. This fee will be charged to your OSHC account and will appear on your account upon receiving this enrolment form. It is compulsory that all families that use the service enrol and complete the enrolment form to ensure our records are up to date so we are aware of which families are using or planning to use the service throughout the year.
CHILD CARE BENEFIT and OSHC PAYMENT AGREEMENT

I have applied for Child Care Benefit and am waiting to receive my Percentage from the FAO. Yes ☐ No ☐

I intend to apply for Child Care Benefit. Yes ☐ No ☐

I do not wish to apply for Child Care Benefit and have completed the request for CCB Reference Number Form. Yes ☐ No ☐

I am aware of arrival and pick-up procedures for my child at this service. Yes ☐ No ☐

I am aware that I will incur a charge for non-cancellation of attendance and/or failure to collect my child by 6pm. Yes ☐ No ☐

CARE ELSEWHERE

I am claiming Childcare Benefit at other approved child care service/s (includes LDC, OSHC, FDC, IHC, OCC) for ☐ children. Please state number.

Please note: Children must have written permission to leave the program without supervision. ie; walking home.

To be signed by both parents/guardians where applicable.

Full Name: ___________________________ Signature: ___________________________

Full Name: ___________________________ Signature: ___________________________