APPLICATION FOR ENROLMENT

1 Birkinshaw Avenue Tranmere SA 5073
Phone 8431 2834 / Fax 8431 2022
Email: oshc@stjotran.catholic.edu.au or 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: oshc@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>
</tr>
</thead>
<tbody>
<tr>
<td>BSC</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>ASC</td>
<td>Part</td>
<td>Full</td>
<td>Part</td>
<td>Full</td>
<td>Part</td>
</tr>
</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 [ ]

Offi ce 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: ______________________________________

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? __________________________________

_________________________________________________________________________________________

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: __________________________________________

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: ____________________________

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? ______________________________________

________________________________________________________________________________________
**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  
- [ ] Child Disability  
- [ ] Respite Purposes  
- [ ] One parent working / One studying  
- [ ] Both parents studying/working  
- [ ] Parents seeking work  
- [ ] Parent  
- [ ] Disability

<table>
<thead>
<tr>
<th>Enrolling Parent/Guardian 1</th>
<th>Parent/Guardian 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title: Mr  Mrs  Ms  Miss  Dr (please circle)</td>
<td>Mr  Mrs  Ms  Miss  Dr (please circle)</td>
</tr>
<tr>
<td>Family Name: ________________</td>
<td>____________________</td>
</tr>
<tr>
<td>Given Name(s): ______________</td>
<td>____________________</td>
</tr>
<tr>
<td>Occupation: __________________</td>
<td>____________________</td>
</tr>
<tr>
<td>Date of Birth: _____________ CRN: _____________</td>
<td>____________________</td>
</tr>
<tr>
<td>Residential Address: ______________</td>
<td>____________________</td>
</tr>
<tr>
<td>Postal Address: ______________</td>
<td>____________________</td>
</tr>
</tbody>
</table>

(mark ‘same as’ above if not different)

Telephone Numbers: Home: ________________  
Work: ________________ Mobile: ________________

Relationship to child: ____________________  
(Father, Mother, Foster Parent etc)  
(Father, Mother, Foster Parent etc)

Contact priority: ____________________

Contact 1  
Name: ____________________  
Mobile: ____________________  
Work: ____________________  
Home: ____________________  
Relationship to child: ____________________  
Date of Birth: ____________________

Contact 2  
Name: ____________________  
Mobile: ____________________  
Work: ____________________  
Home: ____________________  
Relationship to child: ____________________  
Date of Birth: ____________________

Contact 3  
Name: ____________________  
Mobile: ____________________  
Work: ____________________  
Home: ____________________  
Relationship to child: ____________________  
Date of Birth: ____________________

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)
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: _____________________________