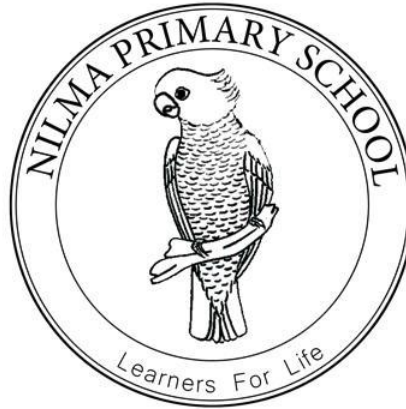


Nilma Primary School

Enrolment Form

CONFIDENTIAL



**Out of School Hours Care
(NPS OSHC)**

**Before School Care
After School Care**

Enrolment Form

CONFIDENTIAL

STUDENT NAME

DETAILS OF CHILD

First Name..... Middle Name.....

Preferred First Name

Surname.....

Address

.....

Male Female (please circle)

Date of Birth.....

Languages spoken.....Main language spoken.....

. 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)

Any special issues in relation to your child e.g. religion, food, etc.?.....

.....

Does either parent/guardian have a disability? YES NO (please circle)

School.....

Homegroup.....Teacher.....

1. DETAILS OF PARENT/GUARDIAN

Name.....

Date Of Birth.....

Address.....

.....

.....

Telephone

(Home).....

(Work).....

(Mobile).....

Employer.....

Occupation.....

Languages spoken.....

Does the child live with this parent/guardian?

YES/NO

Cultural/Religion

(If applicable)

2. DETAILS OF PARENT/GUARDIAN

Name.....

Date Of Birth.....

Address.....

.....

.....

Telephone

(Home).....

(Work).....

(Mobile).....

Employer.....

Occupation.....

Languages spoken.....

Does the child live with this parent/guardian?

YES/NO

Cultural/Religion

(If applicable)

OTHER RESIDENCY ARRANGEMENTS

(Please give details)

Name.....

Address.....
.....

Telephone

(Home).....

(Work).....

(Mobile).....

ACCOUNT DETAILS – invoice to be sent to:

(Please circle)

Parent/Guardian 1.....

Parent/Guardian 2.....

FEES

Have you applied for Child Care Benefit? YES NO (please circle)

(CRN = Customer Reference Number for Child Care Benefit)

Parent/Guardian CRN:.....

Parent/Guardian CRN:.....

Child CRN:.....

TICK THE DAYS YOUR CHILD WILL BE ATTENDING THE SERVICE

PERMANENT BOOKINGS
BEFORE SCHOOL CARE

MONDAY

TUESDAY

WEDNESDAY

THURSDAY

FRIDAY

AFTER SCHOOL CARE

MONDAY

TUESDAY

WEDNESDAY

THURSDAY

FRIDAY

CASUAL/EMERGENCY CARE

Please tick if you will require casual care only

BEFORE SCHOOL

MONDAY

TUESDAY

WEDNESDAY

THURSDAY

FRIDAY

AFTER SCHOOL

MONDAY

TUESDAY

WEDNESDAY

THURSDAY

FRIDAY

Medical Information

Enrolment record addendum for children's services

Child's Name: _____

Child's Date of birth: ____/____/____

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.

Health Information

Does your child have any special needs? Yes No

If yes please provide details of any special needs and any management procedure to be followed with respect to the special need.

Anaphylaxis

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 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 can be found at www.education.vic.gov.au/anaphylaxis

Asthma Yes No

Asthma Medication/Treatment.....

Do you have an Asthma Plan? Yes No

Are there any known triggers?.....
.....

Does your child have any other medical conditions? (e.g. epilepsy, diabetes 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.

.....
.....

Does the child have any dietary restrictions? No Yes (please tick)

If yes, the following restrictions apply:

.....
.....

Does the child have any allergies or sensitivity? No Yes (please tick)

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

.....
.....

Immunisation Records

Has the child been immunised? No Yes (please tick)

*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	2months	4months	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)							

Does your child have a child health record? Yes No

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.

*Other information

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

.....

.....

.....

.....

FAMILY DOCTOR

Doctor's Name.....Phone.....

Name of Practice.....

Address.....

Medicare Number.....

Do you have Private Medical Insurance?

Do you subscribe to an Ambulance Service? YES NO (please circle)

If yes, please state the Ambulance Subscription Number and Category

.....

OTHER INFORMATION

Is there any other information we should know about your child? Likes, dislikes, favourite activities, cultural information etc.

.....
.....
.....
.....
.....
.....

DECLARATION AND CONSENT TO EMERGENCY MEDICAL TREATMENT

I/We(Print full name/s)

Person/s 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 OSHC service in the event of any change to this information
- Agree to collect or make arrangement for the collection of the child referred to in this enrolment form if he/she becomes unwell at the service
- Consent to the staff of the OSHC service seeking medical treatment by a medical practitioner, hospital or ambulance service, or where appropriate, administer such emergency medical treatment as is reasonably necessary and agree to reimburse any necessary expenses incurred by the OSHC service
- Undertake to inform the staff of any absence of my child from the service
- Accept full responsibility for my child's belongings whilst attending the service

PARENT/GUARDIAN SIGNATURE/S.....

DATE

CUSTODY DETAILS

Are there special access/custody arrangements? YES NO (please circle)

If yes, please give details.....
.....
.....

If a court order exists please provide this information to the Coordinator.

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 a parent/guardian to:

- authorise the taking of the child outside the service by a staff member of the service
- Consent to the medical treatment of the child
- Request or permit the administration of medication to the child
- Collect the child

AND/OR

b. Give these powers to someone else,

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

.....
.....

PERSONS/ AUTHORISED

Your consent is required for other people to collect the child from the children’s service and to give consent for medical treatment and consent to administer medication to the child on your behalf. In the table below, please list the details of those people you have authorised to collect the child and are also authorised to consent to medical treatment or who may authorise administration of medication to 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.

In case of accident or injury, trauma or illness when parents/guardians are not available, the person/s listed below are also authorised to pick up the child and take care of them for the day and are authorised to consent to medical treatment or who may authorise administration of medication to the child.

Name/Relationship.....

Address.....

Phone Numbers.....

Name/Relationship.....

Address.....

Phone Numbers.....

Name/Relationship.....

Address.....

Phone Numbers.....

EMERGENCY CONTACTS (Maximum 30 minutes from the service)

Name/Relationship.....

Address.....

Phone Number (Home).....

(Work).....

(Mobile)

Name/Relationship.....

Address.....

Phone Number (Home).....

(Work).....

(Mobile)

PARENT/GUARDIAN SIGNATURE/S

DATE

PERMISSION TO PUBLISH CONSENT

I give permission for my child to be photographed by staff members; I understand that these photos are for the service use only and may be used for promotional material for the service.

YES NO (Please circle)

I give permission for my child to be photographed and/or video taped in the event of media reportage.

YES NO (Please circle)

I give permission for my child's name/s, work, picture/s to be used by the school and OSHC program in promotional material in the schools newsletter, website, SENTRAL, social media and in local press and media.

YES NO (Please circle)

SUNSCREEN CONSENT

I give permission for my child to have a 30+ sunscreen applied as per the service's Sun Smart Policy.

YES NO (Please circle)

POLICY AND PHILOSOPHY STATEMENT

I agree to abide by all policy and philosophy guidelines of the service.

YES NO (Please circle)

PARENT/GUARDIAN SIGNATURE/S

.....

DATE

AUTHORISED PERSONS/

In the case that my child needs to be taken outside of the OSHC premises I authorise the people listed below to give consent on my behalf.

Name/Relationship.....

Address.....

Phone Number (Home).....

(Work).....

(Mobile)

Name/Relationship.....

Address.....

Phone Number (Home).....

(Work).....

(Mobile)

PARENT/GUARDIAN SIGNATURE/S

.....

DATE

PRIVACY NOTIFICATION

Nilma Primary School OSHC uses the enrolment form to collect personal information for the purposes of service enrolment and statistical recording. The information may be shared with funding agencies and administrators for operational purposes only. The information will not be disclosed to any other party except as required by law. You are able to amend or correct information on request, by contacting the service coordinator.

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's Services Regulations 2009 (regulation 35(1) (d-e))

I _____ (name) declare as the person with lawful authority of the child referred to in this enrolment form that the information provided is true and correct and undertake to immediately inform the children's service in the event of any change to this information.

Parent /Guardian Signature: _____ Date: _____

Lawful Authority

Parents

All parents have powers and responsibilities in relation to their children that can only be changed by a court order. The Children's Services Regulations 2009 refer to these powers and responsibilities as "lawful authority". It is not affected by the relationship between the parents, such as whether or not they have lived together or are married. A court order, such as under the Family Law Act, may take away the authority of a parent to do something, or may give it to another person.

Guardians

A guardian of a child also has lawful authority. A legal guardian is given lawful authority by a court order. The definition of "guardian" under the *Children's Services Act 1996* also covers situations where a child does not live with his or her parents and there are no court orders. In these cases, the guardian is the person the child lives with who has day-to-day care and control of the child.

ASTHMA MANAGEMENT FORM

The following confidential information is required to assist in the proper management of a child's asthma, if such help is needed. Please complete and attach to the Medical Consent form. For more information on Asthma see [section 4.5.7 of the Victorian Government Schools' Reference Guide](#). Further information is available from the Asthma Foundation www.asthma.org.au.

Student's name:

Usual signs of asthma: " Wheezing " Chest tightness " Coughing " Difficulty breathing " Difficulty speaking " Other

When completing this form please seek the advice of the asthmatic's doctor if necessary.

1. Usual maintenance regime or medical program followed:

Name of Medication	Method (eg. Puffer & spacer, turbo haler)	When and how much?
---------------------------	--	---------------------------

Does the child require assistance to take their medication?

2. Peak flow readings: BestCritical(bring own peak flow meter)

3. Signs of worsening asthma: " Wheezing " Chest tightness " Coughing " Difficulty breathing " Difficulty speaking " Other:

Medication and treatment to be used during worsening asthma:

4. Medication and treatment to be used during crisis situations:

5. List any known asthma trigger factor(s):

6. Has the person been admitted to hospital due to asthma in the past 12 months?

7. Has the person been on oral cortisone for asthma within the past 12 months? (e.g. Prednisolone, Cortisone, Betamethasone etc.)

8. Has the person ever suffered sudden severe asthma attacks requiring hospitalization?

As separate Asthma form is needed for each child.

ALLERGY MANAGEMENT FORM

The following confidential information is required to assist in the proper management of a child's allergy, if such help is needed. Please complete and attach to the Medical Consent form.

Student's name:

Usual signs of allergy:

When completing this form please seek the advice of the doctor if necessary.

1. Usual maintenance regime or medical program followed:

Name of Medication	Method	When and how much?
--------------------	--------	--------------------

Does the child require assistance to take their medication?

2. What is child allergic to?

3. Signs of worsening allergy:

Medication and treatment to be used during worsening allergy:

4. Medication and treatment to be used during crisis situations:

5. List any known allergy trigger factor(s):

6. Has the person been admitted to hospital due to allergy in the past 12 months?

7. Has the person been on oral medication for the allergy within the past 12 months?

8. Has the person ever suffered sudden severe allergy attacks requiring hospitalization?

A separate Allergy form is needed for each child.

MEDICAL CONDITION MANAGEMENT FORM

The following confidential information is required to assist in the proper management of a child's medical condition, if such help is needed. Please complete and attach to the Medical Consent form. (note from your doctor indicating condition or medication prescription)

Student's name:

What is your child's medical condition?

When completing this form please seek the advice of the doctor if necessary.

1. Usual maintenance regime or medical program followed:

Name of Medication	Method	When and how much?
--------------------	--------	--------------------

Does the child require assistance to take their medication?

2. What are symptoms of the condition?

3. Signs of worsening condition:

Medication and treatment to be used during worsening stage;

4. Medication and treatment to be used during crisis situations:

5. List any known medical trigger factor(s):

6. Has the person been admitted to hospital due to condition in the past 12 months?

7. Has the person been on oral medication for the allergy within the past 12 months?

OTHER INFORMATION

A separate Medical form is needed for each child.