

**Ingle Farm Primary School OSHC & Vac Care
Enrolment Form: Part 1**

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CHILD

Family Name: Gender:
First Name(s): Known as:
Date of birth: / / CRN:
Address No. / Street: Town/ Suburb:
Postcode: Primary Language:
Indigenous status: Aboriginal: Yes / No TS Islander: Yes / No

ELIGIBLE PARENT/GUARDIAN & BILLING DETAILS

Name:
Date of birth: / / CRN:
Relationship to child: Contact Priority: Primary Language:
Address: (h)
(w)
Phone: (h) (w) (m)
Email:

OTHER PARENT/GUARDIAN (if applicable)

Name:
Relationship to child: Contact Priority: Primary Language:
Address: (h)
(w)
Phone: (h) (w) (m)
Email:

PARENTING PLANS / ORDERS relating to this child

EMERGENCY CONTACTS & COLLECTION AUTHORITIES

Name: Contact Priority:
Address: Relationship to child:
Phone: (h) (w) (m)

Name: Contact Priority:
Address: Relationship to child:
Phone: (h) (w) (m)

N.B. It is very important that you tell these people that you have nominated them. In nominating them you give them authority to act on the child's behalf if neither parent can be located, to pick up the child in an emergency and care for the child until s/he can be returned home.

COLLECTION AUTHORITIES ONLY

Name: Relationship to child:
Address:
Phone: (h) (w) (m)

Name: Relationship to child:
Address:
Phone: (h) (w) (m)

N.B. The people nominated here have been given approval only to collect the child and should NOT be contacted in case of an emergency.

Enrolment Form: Part 2

Child's Name:

MEDICAL AND HEALTH INFORMATION

Has the child received all immunisations appropriate for their age? Yes / No

If no, please give details:

I accept full responsibility if my child is not immunised.
Parent / Guardian signature:

Has the child received the following immunisations? (please tick):

12 - 13
years

Diphtheria

Tetanus

Pertussis (Whooping Cough)

Human Papillomavirus (HPV)

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Has the child any conditions / medications that may be effected by OSHC activities?

If yes, please give specifics and any related medication:

Has the child any disabilities? Yes / No Effective date:

If yes, please record specifics:

Has the child any special needs? Yes / No Effective date:

If yes, please record specifics:

Does the child usually require special aids (e.g. glasses, hearing aid etc.)?

If yes, please give details:

Has the child any special dietary needs not related to allergies?

If yes, please give specifics:

Has the child suffered any illness that may re-occur (e.g. chronic ear infection)?

If yes, please give details:

Has the child had any kind of allergic reactions or food intolerances?

Foods:

Reaction / Medication:

Penicillin:

Reaction / Medication:

Others:

Reaction / Medication:

Is there any other medical information we might need to know?

Note: Please supply the service with required medications in original containers with the child's name clearly marked. Please complete a permission to administer medication form together with any medication records where necessary.

Usual Medical attendant

Doctor's name:

Phone No.:

Clinic name:

Address:

Usual Dental attendant

Dentist's name:

Phone No.:

Clinic name:

Address:

Medical Benefits cover with:

Ambulance cover with:

Medicare number: Health Care Card number:

Child's Name:

BSC	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Arrive:							
Depart:							
From: <input type="text"/> / <input type="text"/> / <input type="text"/> for: <input type="text"/> weeks / or until: <input type="text"/> / <input type="text"/> / <input type="text"/> or Ongoing (tick) <input type="checkbox"/>							

ASC	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Arrive:							
Depart:							
From: <input type="text"/> / <input type="text"/> / <input type="text"/> for: <input type="text"/> weeks / or until: <input type="text"/> / <input type="text"/> / <input type="text"/> or Ongoing (tick) <input type="checkbox"/>							

VAC	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Arrive:							
Depart:							
From: <input type="text"/> / <input type="text"/> / <input type="text"/> for: <input type="text"/> weeks / or until: <input type="text"/> / <input type="text"/> / <input type="text"/> or Ongoing (tick) <input type="checkbox"/>							

(e.g. 1. any personal, religious or cultural practices/prohibitions that you would like the service to know or 2. comments on homework, behaviour management etc.)

[illegible]

Please initial next to each item to which you consent.

I have read agreement and signed the direct debit form.	<input type="checkbox"/>
I understand and accept the conditions of the school / OSHC ICT Acceptable Use Policy. I understand that if my child does not follow the rules for ICT use, they will be unable to use the school / OSHC technology for a period of time.	<input type="checkbox"/>
I consent to OSHC educators walking my child to Ingle Farm Children's Centre for the preschool program.	<input type="checkbox"/>
I have completed and signed the Media consent form.	<input type="checkbox"/>
I understand as a Sun Smart service my child must have a bucket hat and that OSHC will supply sunscreen	<input type="checkbox"/>
I give permission for OSHC to supply my child with insect repellent.	<input type="checkbox"/>
I permit OSHC accessing educational, health and development records that are essential to my child's wellbeing, from school, preschool and relevant agencies and understand that confidentiality will be maintained.	<input type="checkbox"/>
I give permission for OSHC staff to check my child's hair for head lice.	<input type="checkbox"/>
I give permission for my child to view "PG"rated programs/movies as selected by the service	<input type="checkbox"/>

I agree to pay the required fees for my child's booked childcare hours and accept the policies and rules of the Service.

I agree that the staff of the Service may administer simple first aid to my child if the need arises.

I understand that if at any time the staff of the Service consider that my child requires emergency medical/hospital/ambulance assistance, they will have the local medical/hospital/ambulance attend my child. I acknowledge that I will be liable for any medical/hospital/ambulance expenses incurred in the treatment of my child.

I certify that the information entered upon this form is true to the best of my knowledge and I undertake to inform the Service if any of these details change.

Parent / Guardian signature: _____ Date: ____/____/____

Interviewed / Accepted by: _____ Date: ____/____/____