

OSHC ENROLMENT APPLICATION

2. If you wish to view the full Policy Information Collection Notification, please contact the College Privacy Officer.

Return this completed form to the OSHC Staff

Please Note: Fees and charges are available on our website: www.woodcroft.sa.edu.au

This application is for:	Parent 1 Information			
Casual Booking Permanent Booking	Enrolling Parent with Centrelink CCS			
	Title: Dr Mr Mrs Ms Other			
Child's Details	Surname:			
Surname:	Given Name:			
Given Names:	Date of Birth:			
Preferred Name:	CRN:			
Date of Birth:	Relationship to Child:			
Gender: Male Female				
CRN:	Residential Address:			
Address:				
	Mailing Address:			
Indigenous Status				
Is your child of Aboriginal or Torres Strait Islander origin?	Home Telephone: Silent: [
(For persons of both Aboriginal and Torres Strait Islander origin,	Home Email:			
mark both 'yes' boxes.)	Work Telephone:			
Yes No	Personal Mobile:			
Yes, Aboriginal Yes, Torres Strait Islander	Parent 2 Information			
Parenting Plans/Orders Relating to this Child	Title: Dr Mr Mrs Ms Other			
(Please supply details)	Surname:			
	Given Name:			
	Date of Birth:			
	Relationship to Child:			
	Contact Priority: 1 2			
	Residential Address:			
	Mailing Address:			
	Home Telephone: Silent: [
Privacy Statement	Home Email:			
1. The information collected in this form is governed by the	Work Telephone:			
Privacy Policy of Woodcroft College Inc.	Personal Mobile			

Medical and Health Information Has the child received all immunisations appropriate for his/ her age? ☐ Yes ☐ No If No, please give details:	Note: Please supply the OSHC staff with any required medications in their original containers with the child's name clearly marked on them. You must complete a 'Permission to Administer Medication Form' and 'Medication Register' form together with any medication records where necessary.			
Has this child received the following immunisations?	Doctor's Name:			
(Please ✓ for yes or mark x for no)	Telephone:			
☐ Hepatitis B (10 - 13 years)	Clinic Name:			
☐ Varocella (Chickenpox) (10 - 13 years)	Address:			
☐ Human Papillomavirus (PHV) (12 - 18 years)	Dentist's Name:			
I accept full responsibility if my child is not immunised.	Telephone:			
Signed by parent/caregiver:	Clinic Name:			
Does this child have any medical conditions/medications that may be affected by OSHC activities?	Address:			
	Do you have insurance for the following?			
	Medical Benefits?			
Does this child have any disabilities? Yes No	Policy #			
If Yes, please give details:	Ambulance Yes No Cover is with			
•	Member #			
	Please supply the following:			
Does this child have any special needs? Yes No	Medicare Number:			
If Yes, please give details:	Health Care Card Number:			
	Emergency Contacts			
Does this child usually require special aids (e.g. glasses, hearing aid, etc)? Yes No If Yes, please give details:	It is important that you advise these contacts that you have nominated them for this responsibility. In nominating them you give them authority to act on your child's behalf if neither parent can be located. This includes collecting the child in an emergency and care for the child until he/she can be returned home.			
Does this child have any special dietary needs NOT related to	Emergency Contact 1 This person will be our initial contact in the case of an emergency if			
allergies (e.g. Coeliac Disease, Diabetes)?	parent/caregivers are not available.			
If Yes, please give specific details:	Surname:			
	Given Name:			
	Relationship to Child:Address:			
Has this child suffered any reoccuring illness (<i>e.g. chronic ear infection</i>)? Yes No If Yes, please give details:	Address:			
	Home Telephone:			
	Work Telephone:			
Has this child had any kind of allergic reactions?	Personal Mobile:			
Yes No Foods Reaction / Medication	Emergency Contact 2			
reaction / Medication	This person will be contacted if Emergency Contact 1 is not available.			
	Surname:			
Denicillin2□ Ves □ No	Given Name:			
Penicillin? ☐ Yes ☐ No Others? ☐ Yes ☐ No	Relationship to Child:			
Others: 11 165 11 NO	Address:			
Is there any other medical information we may need to be aware of?				
	Home Telephone:			
	Work Telephone:			
hild's Name	Personal Mobile:			

Alternative Collection Authority

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

Alteri	native Collector 1
Surna	nme:
	n Name:
Relat	ionship to Child:
Addre	ess:
Home	e Telephone:
Work	Telephone:
Perso	nal Mobile:
Alter	native Collector 2
Surna	nme:
	n Name:
Relat	ionship to Child:
Addre	ess:
Home	e Telephone:
	Telephone:
	nal Mobile:
Con	Sents (please <u>initial</u> next to each item to which you consent)
	I consent for a staff member to apply sunblock to my
	child if required.
	I give consent for my child to be taken by a staff membe to the local hospital or doctors surgery in the event of a
	minor injury.
	I am aware of the policy about sanitising hand gel. I
	accept hand gel will be used to kill germs from my child' hands before they eat afternoon tea.
	I give consent for my child to watch PG rated movies as deemed appropriate by OSHC staff.
Signa	ture:
Date:	

Video/Photography

We believe it is important to capture the children's day through the use of images and video footage to enable us to promote, observe and communicate with staff, parents and the College community. As part of our National Quality Framework, digital media is a good way to show evidence of the great experiences happening in the OSHC Program.

At the start of each year the College will send you a form to opt out of photo and video images of your child being available to the public and used in our promotional material. If you choose to opt out, this advice will be followed when your child is attending OSHC.

Agreements

I/We agree to pay the required fees for my child's booked childcare hours and accept the policies and rules of the Woodcroft College OSHC Program.

If fees are not paid within that time, I/we agree to meet the Administration Costs imposed by the Woodcroft College OSHC and those associated with the collection of late payments and to pay all expenses incurred by the Woodcroft College OSHC including, but not limited to, legal fees, location and service fees and any fees or commissions charged by collection agencies.

I/We accept that where the whole or any part of the fees payable remain unpaid after the due date for payment, the Woodcroft College OSHC may apply an overdue account Administration Fee to the account.

I/We acknowledge that the Woodcroft College OSHC College may vary the fees, at any time, to meet its operating requirements.

I/We acknowledge that the financial liability under this agreement is joint and several. Service of any notice on one of the parents will be effective service on both parents.

Failure to settle any outstanding account in the time and manner stipulated by the Woodcroft College OSHC following a request by the Woodcroft College OSHC to do so, may result in the suspension of service to my/our child.

Continued failure by the parent(s) to settle their account in the time and manner stipulated by the Woodcroft College OSHC will result in the termination of the Agreement by the College by notice in writing to the parent(s).

I/we agree that the staff of the Woodcroft College OSHC Program may administer minor first aid to my child if the need arises.

In an emergency I/we understand that the staff of the Woodcroft College OSHC Program will call for ambulance assistance. I/we acknowledge that I/we will be liable for any medical/hospital expenses incurred in the treatment of my child.

I/We certify that the information supplied on this form is true to the best of my knowledge and I/we undertake to inform the Woodcroft College OSHC Program of any changes to this information.

Parent 1 Signature:		
Date:	_	
Parent 2 Signature:		
Date:		

The Woodcroft College OSHC Program Booking Form is on Page 4 of this document.

Child's Name:

Acknowledgement													
I acknowledge that there	are no changes to p	ersonal details:											
Reception			Year 4										
Signature:													
			Date:										
							Year 2 Signature:			Year 6 Signature:			
							Date:			Date:			
Year 3													
Signature:													
Date:													
Woodcroft Colle Before School Care	ege OSHC Bo Monday	oking Form Tuesday	Wednesday	Thursday	Friday								
Arrive	Monday	Tuesday	Wednesday	Indibudy	IIIday								
Depart	8.30am	8.30am	8.30am	8.30am	8.30am								
From (date)	for	weeks, OR until	OR ongoing (please tick)										
After School Care	Monday	Tuesday	Wednesday	Thursday	Friday								
Arrive	3.15pm	3.15pm	3.15pm	3.15pm	3.15pm								
Depart													
From (date)	for	weeks, OR until		OR ongoing (please tick	k) 🗆								
Further Information is there any further informations or cult bersonal, religious or cult behaviour management, e	mation that you wis ural practices/prohi												
DR OFFICE USE ONLY: terviewed / Accepted by		(name)											

Child's Name: