St Columba College
A joint Anglican and Catholic College

Out of School Hours Care (OSHC) Enrolment Form

CHILD DETAILS

☑ FLEXIBLE / CASUAL ☐ FIXED / ROUTINE

FAMILY NAME: _____ FIRST NAME: _____

PREFERRED NAME: _____ GENDER: ☐ Male ☐ Female

DATE OF BIRTH: _____ / _____ / _____ CRN: _____

RESIDENTIAL ADDRESS: _____

TOWN / SUBURB: _____ POSTCODE: _____

PRIMARY LANGUAGE SPOKEN AT HOME: _____

DOES THE STUDENT IDENTIFY AS BEING OF ABORIGINAL OR TORRES STRAIT ISLANDER DESCENT?

☐ No ☐ Yes, Aboriginal Descent ☐ Yes, Torres Strait Islander Descent

IS THE CHILD IN STATE CARE? ☐ No ☐ Yes

	ENROLLING PARENT / GUARDIAN AND BILLING DETAILS	OTHER PARENT / GUARDIAN (if applicable)
SURNAME		
GIVEN NAME		
RELATIONSHIP TO CHILD		
CONTACT PRIORITY	☐ Yes ☐ No	☐ Yes ☐ No
DATE OF BIRTH		
CRN		
PRIMARY LANGUAGE SPOKEN AT HOME		
CORRESPONDENCE & BILLING ADDRESS		
	POSTCODE	POSTCODE
HOME PHONE		
WORK PHONE		
MOBILE PHONE		
EMAIL ADDRESS		
WORKPLACE/EMPLOYER		
WORKPLACE ADDRESS		
	POSTCODE	POSTCODE

St Columba College
A joint Anglican and Catholic College

EMERGENCY CONTACTS & COLLECTION AUTHORITIES			
SURNAME			
GIVEN NAME			
RELATIONSHIP TO CHILD		CONTACT PRIORITY	
HOME PHONE			
WORK PHONE			
MOBILE PHONE			

SURNAME			
GIVEN NAME			
RELATIONSHIP TO CHILD		CONTACT PRIORITY	
HOME PHONE			
WORK PHONE			
MOBILE PHONE			

NOTE: It is very important 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 / guardian 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	
SURNAME	
GIVEN NAME	
RELATIONSHIP TO CHILD	
HOME PHONE	
WORK PHONE	
MOBILE PHONE	

SURNAME	
GIVEN NAME	
RELATIONSHIP TO CHILD	
HOME PHONE	
WORK PHONE	
MOBILE PHONE	

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

St Columba College
A joint Anglican and Catholic College

MEDICAL AND HEALTH INFORMATION

HAS THE CHILD RECEIVED ALL IMMUNISATIONS APPROPRIATE FOR HER / HIS AGE? ☐ Yes ☐ No

☐ I HAVE ATTACHED A COPY OF IMMUNISATION RECORD

IF NO, PLEASE GIVE DETAILS: _____

_____

HAS THE CHILD RECEIVED THE FOLLOWING IMMUNISATIONS (10-15 YEARS)? please tick ✓

☐ HEPATITIS B

☐ DIPHTHERIA

☐ TETANUS

☐ PERTUSSIS (Whopping Cough)

☐ VARICELLA (Chickenpox)

☐ HUMAN PAPILLOMAVIRUS (HPV)

I ACCEPT FULL RESPONSIBILITY IF MY CHILD IS NOT IMMUNISED.

PARENT / GUARDIAN SIGNATURE: _____

In order for us to meet your child's needs, it is very important that you provide information on any condition that may impact on the child's ability to participate in the OSHC program, or may require particular medication, attention or support (please provide specifics).

1. MEDICAL CONDITION ☐ No ☐ Yes _____
2. MEDICATIONS ☐ No ☐ Yes _____
3. DISABILITIES ☐ No ☐ Yes _____
   Effective Date: _____ / _____ / _____
4. SPECIAL NEEDS ☐ No ☐ Yes _____
   Effective Date: _____ / _____ / _____
5. SPECIAL AIDS (glasses, hearing aids, etc.) ☐ No ☐ Yes _____
6. SPECIAL DIETARY NEEDS (not related to allergies) ☐ No ☐ Yes _____
7. REOCCURRING ILLNESS (chronic ear infection, etc.) ☐ No ☐ Yes _____

HAS THE CHILD HAD ANY KIND OF ALLERGIC REACTIONS?

FOODS:	REACTION / MEDICATION:
_____	_____
_____	_____
_____	_____
PENICILLIN:	REACTION / MEDICATION:
_____	_____
OTHERS:	REACTION / MEDICATION:
_____	_____
_____	_____

St Columba College
A joint Anglican and Catholic College

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: _____

CLINIC NAME: _____ PHONE NUMBER: _____

ADDRESS: _____ POSTCODE: _____

USUAL DENTAL ATTENDANT DENTIST'S NAME: _____

CLINIC NAME: _____ PHONE NUMBER: _____

ADDRESS: _____ POSTCODE: _____

MEDICAL BENEFITS COVER WITH: _____

AMBULANCE COVER WITH: _____

MEDICARE NUMBER: _____ HEALTH CARE CARD NUMBER: _____

IS THERE ANYTHING MORE WE NEED TO KNOW?

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

_____

_____

_____

_____

_____

_____

_____

PARENTING PLANS / ORDERS RELATING TO THIS CHILD

_____

_____

_____

_____

_____

_____

_____

St Columba College
A joint Anglican and Catholic College

CONSENTS

- I consent for my child to take part in supervised walking excursions within the local areal as part of the Centre's program. ☐
- I consent for my child to be photographed and for their image and name to be published in circumstances the Director deems to be appropriate. ☐
- I consent for a staff member to apply sunblock to my child if required. ☐
- I consent for a staff member to apply insect repellent to my child if required. ☐
- I consent to the Director obtaining information from the College Nurse regarding my child's medical or health issue. ☐
- I consent to my child participating in centre based activities organised for the days my child will be attending including watching PG rated videos and DVD's. ☐

AGREEMENTS

- I agree to pay the required fees for my child's booked childcare hours and accept the policies and rules of the Service. (Refer to the OSHC Fees published on the College website http://stcolumba.sa.edu.au/enrolment/oshc) Please be aware that fees may change at any time. ☐
- 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: _____ / _____ / _____

OFFICE USE ONLY	
INTERVIEWED / ACCEPTED BY:	DATE: _____ / _____ / _____

President Avenue, Andrews Farm South Australia 5114
T | 08 8254 0603 **M |** 0408 840 106 **E |** oshc@stcolumba.sa.edu.au **| www.stcolumba.sa.edu.au**