



# ST MATTHEWS OUTSIDE SCHOOL HOURS CARE ENROLMENT FORM 2012

Please complete all sections in **BLOCK LETTERS**

**Child Details**

Child's Name 1  Male/Female  Date of Birth

CRN  School  Teachers Name

Child's Name 2  Male/Female  Date of Birth

CRN  School  Teachers Name

**Parent/ Legal Guardian 1**

First Name  Surname  CRN

Date of Birth  Home Phone  Mobile Phone

Work Phone  Email

Home Address  Suburb  Post code

**Parent/ Legal Guardian 2**

First Name  Surname  CRN

Date of Birth  Home Phone  Mobile Phone

Work Phone  Email

Home Address  Suburb  Post code

**For our statistics...**

Are you a single parent? YES  NO  Your family's country/countries of origin?

Do you identify as Aboriginal or Torres Strait Islander? YES  NO

Languages spoken at home, if other than ENGLISH

**Emergency Contacts and People Authorized to collect your Child/ Children**

Name  Relationship  Authorised to collect

Home Phone  Mobile Phone  Work Phone

Address

Name  Relationship  Authorised to collect

Home Phone  Mobile Phone  Work Phone

Address

Please note that we will not under any circumstances allow any person other than those on the list to collect your child unless proper notification is received from you in writing. This authority may be revoked in writing at any time

**Medical Details (please attach more information as required)**

Child 1  Medical Condition

Does your child have any allergies or food/drug sensitivities? YES  NO

If YES please give details:

Is there any other information, including cultural or religious requirements you feel staff should be aware of regarding your child?

Has your child received all immunisation requirements including Tetanus? YES  NO

Child 2  Medical Condition

Does your child have any allergies or food/drug sensitivities? YES  NO

If YES please give details:

Is there any other information, including cultural or religious requirements you feel staff should be aware of regarding your child?

Has your child received all immunisation requirements including Tetanus? YES  NO

**Family Doctors Information**

Name  Phone Number  Ambulance Scheme

Address

Medicare Number

**Custody Details**

For the Children listed in this enrolment is there any custody or special access arrangements? YES  NO

If yes please give details (To be enforced documents must be provided)

**Booking Information**

Permanent Bookings  For Children attending a program on specific days. (Please complete the schedule below)

Casual Bookings  For Children who do not attend consistently on the same days.

**Before school Care only available at Florey, St John and St Matthews OSHC programs.**

Permanent Booking Child 1  Start Date

	Mon	Tues	Wed	Thurs	Fri	Mon	Tues	Wed	Thurs	Fri
Before School Care <b>wk 1</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>wk 2</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After School Care <b>wk 1</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>wk 2</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Permanent Booking Child 2  Start Date

	Mon	Tues	Wed	Thurs	Fri	Mon	Tues	Wed	Thurs	Fri
Before School Care <b>wk 1</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>wk 2</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After School Care <b>wk 1</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>wk 2</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Authorisations and conditions of care

**A PARENT OR LEGAL GUARDIAN MUST SIGN THE FOLLOWING AUTHORISATIONS AND ALL SECTIONS MUST BE COMPLETED. IF NOT, CARE CANNOT COMMENCE.**

### Parent/Guardian Declaration

1. I/We give permission for my child/ren to watch (PG) rated movies **Yes**  **No**
  2. I/We give permission for my child/ren to have their photo taken and displayed at the Program and in Belconnen Community Service material. **Yes**  **No**
  3. I/We give permission for my child/ren to go on walks with the program in the local area. **Yes**  **No**
  4. I/We give permission for staff to administer Paracetamol (e.g. Panadol) to my/our child/ren according to the directions if my/our child/ren develops a high temperature. **Yes**  **No**
- I/We understand I/We will be notified before administering, or if non-contactable, as soon as possible afterwards.
5. I/We give permission for the staff of Belconnen Community Service Out of School Hours Care Program to give basic first aid treatment in the event of any minor injury to my/our child/ren.
  6. In the event of accident or serious illness of my/our child/ren, I/We give permission for the staff to seek medical attention or arrange ambulance transport to hospital if considered necessary for the welfare and safety of my/our child/ren. I/We understand that I/We will be required to pay for any costs associated with transport and/or treatment of my/our child/ren.
  7. I/We agree to comply with all Government requirements in relation to the Centre and its service.
  8. I/We agree to pay the fortnightly fee by the designated time and nominated payment method on the due day as determined by Belconnen Community Service and I/we agree that a late payment fee will apply if I/we default.
  9. I am/We are aware that it is my/our responsibility to maintain my/our account and keep payment up to date.
  10. I am/We are aware that it is my/our responsibility to maintain a current Family Assistance Income Assessment Notice for Child Care Benefit purposes.
  11. I am/We are aware that Fourteen (14) days notice in writing of cancellation of care must be given in advance; otherwise fees will continue to be charged.
  12. I am/We are aware that my/our child/ren will be excluded from care at the Centre if he/she has contracted a contagious disease or condition. I/We understand that the child/ren will be accepted back into the Centre upon provision of a 'clearance certificate' for the child/ren from a medical practitioner.
  13. I am/We are aware that sickness and non-attendance days are payable to ensure our child's place at the Centre.
  14. I/We understand that a system of payment for late departures operates at the Centre to cover overtime payments due to staff. I am/We are aware that I am/We are obliged to pick up my/our child/ren as negotiated with the Centre. Any late collection will result in a fee being imposed.
  15. I am/We are aware that where Childcare Assistance is not available I am/We are responsible for the total amount of the fees. I am/We are aware that any failure to pay due fees within 28 days may result in cancellation of care.
  16. I/We agree to provide the Centre with all information regarding the health of my/our child/ren and any other information required by the Centre.
  17. I am/We are aware that the Centre may occasionally have visitors to the Centre and have volunteers that may assist at the Centre. I/We give consent to my/our child/ren being in the presence of visitors or volunteers, with the Centre's appropriate supervision.
  18. I/We agree to pay outstanding childcare fees and cancellation fees where applicable together with all debt recovery expenses including late payment fees, mercantile agents fees, court costs and legal fees reasonably incurred, will be added to the total amount due.
  19. The information I have provided in this form is correct.

The continuation of all enrolments for School Age Care Services is subject to fees being paid in accordance with Belconnen Community Services payment terms. Enrolments and accounts are reviewed regularly and BCS reserves the right to cancel an enrolment if fees are not up to date. An enrolment for a new term will not be renewed where an account remains in arrears.

I/We agree to abide by the conditions of use of the Centre and this Agreement.

I/We agree to be responsible for payment of Belconnen Community Service outside School Hours Care account for the children named in this enrolment.

Parent Signature

Date

Parent Signature

Date

Please return Completed enrolments to:

Children's Services Administration Team

Kippax Health Centre

Kippax, Holt, ACT 2615

Phone: 02 6278 8188 Fax: 02 6255 1425

Enquires: [csat@bcsact.com.au](mailto:csat@bcsact.com.au)

[www.bcsact.com.au](http://www.bcsact.com.au)

## Additional Support Needs

**Does your child have a diagnosed disability, or developmental concern?**

---

---

**Medical Information:** (What we need to know to care for your child?)

---

---

**Support Requirements:** (please let us know how your child needs assistance, with eating, with communication, with self help skills)

---

---

---

**Communication Method:** (does your child use COMPIC, or sign language, or non verbal communication, or other?)

---

---

---

**Mobility:**(does your child need assistance with movement in the program?)

---

---

**What are your child's interests and likes?** (hobbies/activities/music/food):

---

---

---

**What does your child dislike?**

---

---

---

**What goals would you like your child to achieve while accessing School age care?**

---

---

---

**Is there anything else you want us to know about your child and family?**

---

---

---

---

Thank you for completing this form. If you have any questions or concerns, please talk to the coordinator at your child's program.

Where appropriate, BCS will apply for funding to have another staff member available in the program, to allow higher ratio of staff to children. You may be asked to provide further information to support this application.