

SHOALHAVEN HEADS OOSH

47 Ravenscliffe Road

Shoalhaven Heads NSW 2535

Phone: 0422 959 264 Email: ashmay@live.com.au

ENROLMENT FORM

Mother's/Carer's Details

First Name: _____ Regularly known as: _____

Middle Name: _____ Surname: _____

Date of Birth: _____ Cultural Background: _____

Home Address: _____

Suburb: _____ Post Code: _____

Contact Phone Number: _____

Primary Email Address: _____

Mother's Employment Details

Employer Name: _____

Employer Address: _____

Work Phone Number: _____ Occupation: _____

Father's/Carer's Details

First Name: _____ Regularly known as: _____

Middle Name: _____ Surname: _____

Date of Birth: _____ Cultural Background: _____

Home Address: _____

Suburb: _____ Postcode: _____

Contact Phone Number: _____

Primary Email Address: _____

Father's Employment Details

Employer Name: _____

Employer Address: _____

Work Phone Number: _____ Occupation: _____

Family Status

Please tick:

☐ Both parents at home

☐ Shared Custody

☐ Sole Parent

☐ Other _____

Custody Arrangements

If you are separated or divorced, who has legal custody of the child?

Mother / Father / Both **(Please Circle)**

Mother's access arrangements: _____

Father's access arrangements: _____

Are there any court orders relating to the powers and responsibilities of the parents in relation to the child/children or access to the child?

Yes / No **(Please Circle)** – if yes, please supply a copy of the court orders.

Childcare Benefit

Is the Child Care Benefit registered under the mother or father's name?

CRN of registered parent: _____

How many other children do you have in Daycare/Preschool? _____

CHILDREN'S DETAILS

Child 1:

First Name (birth name): _____ Regularly known as: _____

Middle Name: _____ Surname: _____ Male/Female _____

Date of Birth: _____ Birth Place: _____

Language spoken at home: _____

Is the child of Aboriginal or Torres Strait Islander Origin?

- ☐ Yes, Aboriginal
☐ Yes, Torres Strait Islander

Grade in 2019: _____ Interests: _____

Health & Medical Information

Do you give permission for the Co-Ordinator/Assistant Co-Ordinator to administer Paracetamol to this child should their temperature reach 38 degrees or higher? Yes / No **(Please circle one)**

Does this child suffer from Anaphylaxis? Yes / No **(Please circle one)**

If yes, you will be asked to provide an Action Plan from your own doctor and your own EpiPen.

Does your child have any other Allergies: (eg: food, medication, animals or insects)? Yes / No **(Please circle one)**

If yes, what are they allergic to? _____

Symptoms relating to your child's allergy: _____

Treatment required: _____

Does your child suffer from Asthma? Yes / No **(Please circle one)** If yes, you will be asked to fill out an Asthma Plan & provide their own puffer & spacer.

What are the triggers for your child's asthma? _____

If your child has a medical condition, do you give permission for the staff at O.O.S.H to display a photograph of your child and a description of the medical condition? This is to familiarise all staff with your child and their special needs
Yes / No **(Please circle one)**

Does your child take medication on a regular basis Yes / No **(Please circle one)**

If yes, please list: _____

Dietary Requirements

Is your child vegetarian? Yes / No **(Circle one)**

If yes, do they eat eggs? Yes / No **(Circle one)**

Does your child have any other dietary requirements (eg: Vegan, lactose intolerant, gluten intolerant)? _____

Does your child have any other Medical Conditions (eg: disabilities, illnesses, speech, sight or hearing)? _____

***PLEASE PROVIDE O.O.S.H WITH A COPY OF YOUR CHILD'S
IMMUNISATION HISTORY STATEMENT**

Medical Information

Medicare Number: _____

Medicare Expiry Date: _____

Doctor's Name: _____

Address & Phone Number: _____

Dentist's Name: _____

Address & Phone Number: _____

Emergency Contacts & Authorised People to collect my child/ren:

Please note, if you require someone to pick up your child from OOSH who are **NOT** on the list, you will need to provide that permission in writing, (phone calls are not sufficient). All collectors are required to show photo ID **EVERY** time they arrive at the centre. Under no circumstances will any child be permitted to leave the centre without these conditions being met.

Authorised person to collect my child from OOSH: (1)

Full Legal Name: _____ Known as: _____

Relationship to child: _____

Address: _____

Mobile Number: _____

Do you permit this person to be notified if the parent/guardian cannot be contacted in relation to any accident/illness? Yes / No **(circle one)**

Authorised person to collect my child from OOSH: (2)

Full Legal Name: _____ Known as: _____

Relationship to child: _____

Address: _____

Mobile Number: _____

Do you permit this person to be notified if the parent/guardian cannot be contact in relation to any accident/illness? Yes / No **(circle one)**

NON-AUTHORISED COLLECTORS

The following people are **under no circumstances** to collect my child/children from Shoalhaven Heads OOSH at any given time. (If a child is subject to an access order or agreement, the OOSH must have a copy on record plus any subsequent alteration registered by the court.

1. _____ Relationship to child: _____
2. _____ Relationship to child: _____

Enrolment Conditions:

Health and Safety

I/We hereby give permission for the staff of Shoalhaven Heads OOSH to seek medical attention for my child/children in the event of an accident or emergency. I/We give permission for my/our child/children to be transported by ambulance if it is ever required and I/We accept full responsibility for all reasonable costs incurred (_____ **please initial**)

I/We give permission for the staff of Shoalhaven Heads OOSH to administer Ventolin to my child/children if at any time they are having difficulty breathing (_____ **please initial**)

I/We give permission for the staff at Shoalhaven Heads OOSH to apply sunscreen to my child/children(_____ **please initial**)

General

I/We understand that video DVD's that are rated 'G' & "PG" will be shown at the centre. I/We give permission for my child/children to view these movies (_____ **please initial**)

I/We understand that failure to comply with OOSH guidelines will result in my child/children's placement being cancelled (_____ **please initial**)

I/We understand that it is my/our responsibility to notify the centre immediately should any of the above information change (_____ **please initial**)

I /We give Shoalhaven Heads OOSH permission to photograph my child/children for a range of purposes including; Accreditation, posters, programming and children's profile books. I understand that if my child/children appears in a photo with another child/children, that photo will be shared amongst all the children in that photo (_____ **please initial**)

Privacy Note: The information recorded on this form and details advised by Centrelink are for OOSH purposes only and will not be given to any other person/persons without your prior permission. Exceptions to this policy are **Department of Community Services and/or Police.**

Mother's Signature: _____ **Date:** _____

Father's Signature: _____ **Date:** _____

BOOKING DETAILS

Position required: **Permanent or Casual (Please circle)**

Day/days of the week required: **(Please tick)**

Before School Care

- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday

After School Care

- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday

Start Date: _____ **Am or Pm:** _____

I/We understand that there is a \$30.00 enrolment fee per family, which is due during the first week of my child/children attending (_____ **please initial**)

I/We understand that there is one weeks' notice required for any change or cancellation to my booked days (_____ **please initial**)

I/We understand that should we fail to advise the OOSH that my child/children will be absent from a booked OOSH session and the centre is not notified, I/We will charged \$10.00 in addition to the session fee (_____ **please initial**)

Additional Notes: _____

