

PARRAMATTA EAST OSHC CENTRE Enrolment Form

| | | |
|--------------------|---------------------|------------------------------|
| Child's Given Name | Child's Family Name | Male/Female |
| Address | | |
| Home Phone | Child's DOB | Legal Guardian |
| | | Primary Language |
| OSHC Start Date | Date Started School | Child's CRN |
| | | Religion/Cultural Background |

| | PARENT 1 (fees billed to this person) | PARENT 2 |
|-----------------------|--|----------|
| Relationship to child | | |
| Given Name | | |
| Family Name | | |
| Home Address | | |
| DOB | | |
| CRN | | |
| Phone (H) | | |
| Phone (M) | | |
| Phone (W) | | |
| Email | | |

| MEDICAL INFORMATION | Has your child had any of the following:- | | |
|---|---|-------------|-------|
| Doctors Name | German Measles | Chicken Pox | Other |
| Address | Mumps | Hepatitis | |
| | Measles | | |
| Phone No | Is there any other information you wish us to know about your child? (Special food requirements/religious considerations/ fears etc) | | |
| Contact Doctor Yes / No | | | |
| Medicare No | | | |
| Private Health Fund Particulars | | | |
| Is your child on any regular medication or have any disabilities, food sensitivities or allergies we should know about? No / Yes (give details) | | | |

List at least 2 people who are authorised to collect your child and at least 2 people that we may contact if we cannot contact you in an emergency (they can be the same persons)

| Alternative Contact Information | Contact 1 | Contact 2 | Contact 3 |
|--|-----------|-----------|-----------|
| Person's Name | | | |
| Relationship to child | | | |
| Home Address | | | |
| Phone (H) | | | |
| Phone (W) | | | |
| Phone (M) | | | |
| Emergency. Release | Yes / No | Yes / No | Yes / No |
| Authority to pick up | Yes / No | Yes / No | Yes / No |
| Is there anyone prohibited from having contact with or collecting the child? (Court Order required if Parent is prohibited) | | | |

In the event of an emergency, illness or accident concerning my child and the teacher being unable to contact me or other persons so authorised by me, I consent to the Centre seeking on my behalf, medical, dental, hospital and ambulance attention for my child and I accept full liability for any medical, dental, hospital and ambulance expenses as may be incurred

PRIORITY OF ACCESS GUIDELINES

Under our agreement with The Australian Commonwealth Government for Childcare Benefit approval we must offer places first to parents/carers who meet the priority of access guidelines stipulated. To assist us to determine your "need" for childcare support, in accordance with this access system, please indicate the following

| | | | |
|---|-------|-------------------------------|-------|
| Whether your childcare needs are work/study related | Y / N | Disabled person in the family | Y / N |
| Aboriginal/Torres Strait Islander family | Y / N | Single parent | Y / N |
| Lower income | Y / N | Socially isolated | Y / N |
| Non English speaking background | Y / N | | Y / N |

I have read and understood the Centre Information Booklet and agree to abide by the Policies, Procedures and conditions described therein.

I consent for the use of my child's photograph in professional journals and for Centre publicity materials (no names will be given):

I understand that if I do not provide the CRN and date of birth for my child and myself I will not be eligible to receive CCB funding.

Signed:

Date:

Office use only

| | | | |
|-----------------------|----------------------------|-------------------------|-----------------------------|
| Entered into Kiincare | Registration & Bond billed | Booking confirmed | Orientation Visit conducted |
| | Statement Issued | ID no advised to parent | Date Sign |