



Child's Details

Surname	Given name(s)
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
School attending <input type="checkbox"/> Blackfriars <input type="checkbox"/> St Dominic's	Year level / Teacher
CRN Number (if eligible)	
Indigenous status: <input type="checkbox"/> Aboriginal YES / NO <input type="checkbox"/> Torres Strait Islander YES / NO	

Enrolling Parent/Caregiver and Billing Details

Surname	Given name(s)
Relationship to child	Title <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/> Other
Occupation	Employer
Home telephone	Business telephone
Mobile telephone	Employer address
Address	Email
Suburb	Postcode
CRN number (if eligible)	Date of Birth (for CRN)
Contact Priority <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	
I am claiming Childcare Subsidy at other Approved Childcare Service/s (which includes LDC, OSHC, FDC, IHC, OCC) for this number of children	

Other Parent/Caregiver Details

Surname	Given name(s)
Relationship to child	Title <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/> Other
Occupation	Employer
Home telephone	Business telephone
Mobile telephone	Employer address
Address	Email
Suburb	Postcode
Contact Priority <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	

Emergency Contact Details

PLEASE NOTE: It is very important that 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 can be located, to pick up the child in an emergency and care for the child until s/he can be returned home

Name	Name
Relationship to child	Relationship to child
Home telephone	Home telephone
Business telephone	Business telephone
Mobile telephone	Mobile telephone
Contact Priority <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Contact Priority <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4

Collection Authorities Only

PLEASE NOTE: The people nominated here have been given approval only to collect the child and will NOT be contacted in the event of an emergency

Name	Name
Relationship to child	Relationship to child
Home telephone	Home telephone
Business telephone	Business telephone
Mobile telephone	Mobile telephone

Please provide photo ID of collection authority personnel. i.e. driver's license. This is to assist staff with identifying those with collection authority.

Medical and Health Information

Does your child need special aids or equipment (e.g. glasses, hearing aid, calipers)? Yes No

If Yes, please provide details:

Has your child received all immunisations appropriate for her/his age? Yes No

If No, please provide details:

Has your child any conditions / medications that may be affected by OSHC activities? Yes No

If Yes, please give specifics and any related medication:

Does the child have any disabilities? Yes No Effective date: / /

If Yes, please record specifics:

Does the child have any special needs? Yes No Effective date: / /

If Yes, please record specifics:

Has the child any special dietary needs not related to allergies? Yes No

If Yes, please give specifics:

Has the child suffered any illness that may re-occur (e.g. chronic ear infection)? Yes No

If Yes, please give details:

Has the child had any kind of allergic reactions?

Foods	Reaction / Medication
Penicillin	Reaction / Medication
Others	Reaction / Medication

Is there any other medical information we might need to know? Yes No

If Yes, please give details:

Usual Medical Attendant	Usual Dental Attendant
Doctor's Name	Dentist's Name
Clinic Name	Clinic Name
Telephone	Telephone
Address	Address

All medication must be supplied in the original container with the child's name clearly marked on the container. A permission to administer medication form must be signed by the parent before medication can be administered by OSHC staff. If medication to be supplied is due to an ongoing medical illness then an action plan must be provided by your child's Doctor.

Signed	Date
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Custody (to be completed if custody is an issue for the family)

Are parents separated or divorced? Yes No

Do the children have contact with the non-custodial parent? Yes No

Is anyone legally denied access to the child/children? Yes No

Who?

Custody Number

Is there additional information regarding separation or custody that OSHC staff may need to know?

Religious and Cultural Preferences

Child's Religion

Mother's Country of Birth

Father's Country of Birth

Please describe any child/family preferences or further information that OSHC staff should be aware of (i.e. cultural, religious etc.)

Ambulance Cover

After attempts have been made to notify parents/guardians/emergency contacts in the event of an emergency situation, I authorise OSHC Staff to seek medical, hospital and/or ambulance services for my child/children. I understand that medical records/relevant information relating to my child will accompany him/her. I give permission for an exchange of information to the appropriate person/s. I understand that this information will be treated confidentially.

Signed

Date

Children enrolled at Blackfriars Priory School are covered for Ambulance Service at Before School, After School, Pupil Free days and Vacation Care.

Legal responsibility for paying Ambulance Service fees for children not enrolled in Blackfriars Priory School rests with the parent or guardian of the child. The Ambulance Service will render an account in the name of the parent/guardian concerned. This is in accordance with the requirements of the Ambulance Services Act 1992. If the parent or guardian is not a member of the ambulance service but has some form of insurance which covers ambulance services then the parent/guardian must submit the account to that insurer for payment.

I/We on behalf of the child/ren named on this form have ambulance insurance cover with St John Ambulance Yes No

Any other insurer details

Is the child covered by a private medical benefits fund as well as Medicare? Yes No

Medicare Number

Medicare Expiry Date

Private Health Insurance Fund

Contribution Number

Important Information

Is there anything more we need to know? (e.g. comments on homework, behaviour management, etc.)

Bookings

I require a casual booking for OSHC Yes No

I require a permanent booking for OSHC Yes No
If Yes, please complete the Term Booking Form

Consents

I give permission and consent for:

- My child/children to participate in supervised walks/visits to the local shop etc as part of the OSHC program. Yes No
- OSHC staff to apply sun block to my child if required. Yes No
- My child/ children to wear no shoes inside if the weather is hot. Yes No
- OSHC staff to exchange information relating to my child/children with school staff and appropriate persons (i.e. in an emergency situation – special needs for my child/children). I understand that this information will be handled confidentially. Yes No
- My child to be photographed and for their image, name and work to be published in OSHC letters, booklets and newsletters. Yes No
- My child to be photographed, and for their image and work to be posted on Blackfriars social media pages. Yes No
- I consent for my child to be photographed, and their image and work to appear on the Blackfriars website. Yes No

Agreements

- I have read the OSHC information package and am aware of and agree to comply with the services, policies and procedures as outlined. Yes No
- In an emergency if I am unable to be contacted I give permission for medication to be administered to my child/ children. I understand that this will only be after permission is received from a Medical Practitioner. Yes No
- I understand the information provided on this Enrolment Form is collected for the purpose of registration, planning, reporting and evaluating; that the information may be disclosed to and used for the purposes by Commonwealth and State government departments and their agencies; and may otherwise be disclosed without consent where required by law. Yes No

Enrolling Parent/Caregiver Signature

Date

I agree to pay the required fees for my child/children's care. I certify that the information on these forms are true to the best of my knowledge and I undertake to inform the OSHC Director if any details change.

Enrolling Parent/Caregiver Signature

Date

Once this enrolment form has been processed you will receive an activation email from XAP. Please complete the online account activation and payment agreement for your bookings to be accepted.

Cancellation Fees

I acknowledge the following:

Sign / Initial

- If a booking for After School Care is no longer required notification must be made by SMS or email.
- If a booking for After School Care or Partial Closure Days or Pupil Free Days is no longer required cancellations need to be made by midday on the day before care is required or the full session fee will be charged. This includes cancellation due to illness.
- Vacation Care bookings require a 50 percent booking fee to be paid upfront. In case of cancellation the booking fee will not be refunded.
- When a booking for Vacation Care or full closure days is no longer required notification must be made by SMS or email.
- If a booking for Vacation Care is no longer required the full session fee will be charged. This includes cancellation due to an illness.
- If a booking for Before School Care is no longer required, cancellation must be made by SMS or email before 4pm the day before care is required or the full session fee will be charged. This includes cancellation due to an illness.