



Xavier Outside School Hours Care

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ENROLMENT FORM 2017

Child/ren's Information:

CHILD 1

Surname: First Names:

Address: Post Code:

Date of Birth: M / F:

Centrelink Customer Reference Number (CRN):

Is your child of Aboriginal/Torres Strait Islander descent? YES NO

Cultural considerations:

Country of birth: Languages spoken at home:

Does your child have any specific healthcare needs?: Anaphylaxis, Asthma, Allergies, Dietary, Medical or any other conditions: YES NO

If yes, please provide further information and a medical management action or care plan, anaphylaxis medical management plan or risk minimisation plan to be followed with respect to a specific healthcare need, medical condition, allergy or dietary restriction:

.....
.....

Does your child have any other additional needs?

.....

CHILD 2

Surname: First Names:

Address: Post Code:

Date of Birth: M / F:

Centrelink Customer Reference Number (CRN):

Is your child of Aboriginal/Torres Strait Islander descent? YES NO

Cultural considerations:

Country of birth: Languages spoken at home:

Does your child have any specific healthcare needs?: Anaphylaxis, Asthma, Allergies, Dietary, Medical or any other conditions: YES NO

If yes, please provide further information and a medical management action or care plan, anaphylaxis medical management plan or risk minimisation plan to be followed with respect to a specific healthcare need, medical condition, allergy or dietary restriction:

.....
.....

Does your child have any other additional needs?

.....

CHILD 3

Surname: First Names:

Address: Post Code:

Date of Birth: M / F:

Centrelink Customer Reference Number (CRN):

Is your child of Aboriginal/Torres Strait Islander descent? YES NO

Cultural considerations:

Country of birth: Languages spoken at home:

Does your child have any specific healthcare needs?: Anaphylaxis, Asthma, Allergies, Dietary, Medical or any other conditions: YES NO

If yes, please provide further information and a medical management action or care plan, anaphylaxis medical management plan or risk minimisation plan to be followed with respect to a specific healthcare need, medical condition, allergy or dietary restriction:

.....

Does your child have any other additional needs?

.....

Child/ren's Medical Practitioner or Medical Service:

Name:.....

Address:.....

Telephone No: Medicare No:.....

We regret that we are unable to provide care for children who are sick or have a communicable illness. In such an event if we are unable to contact you or your emergency contacts we may deem it necessary to call an ambulance.

Education and Care Services National Regulations Regulation 162(a)(b)

Bookings Request:

Start Date: Bookings will be confirmed with availability.

CHILD 1	Monday	Tuesday	Wednesday	Thursday	Friday
Before School					
After School					
Vacation Care					

CHILD 2	Monday	Tuesday	Wednesday	Thursday	Friday
Before School					
After School					
Vacation Care					

CHILD 3	Monday	Tuesday	Wednesday	Thursday	Friday
Before School					
After School					
Vacation Care					

Confirmation regarding days needed for vacation care will be confirmed before each holiday period begins

Parent/Guardian Information:

Parent/Guardian (Account Holder)	Parent/Guardian
Name:	Name:
DOB: CRN:	DOB: CRN:
Address:	Address:
P/C:	P/C:
Phone:	Phone:
Mobile:	Mobile:
Email:	Email:
Please email: Account <input type="checkbox"/> Newsletter <input type="checkbox"/>	
Place of Work:	Place of Work:
Address:	Address:
Phone:	Phone:
Country of Birth:	Country of Birth:
Languages Spoken at Home:	Languages Spoken at Home:
Cultural Considerations:	Cultural Considerations:
Care required for (work/study/respite/other):	Care required for (work/study/respite/other):

Child Care Benefit (CCB) and Child Care Rebate (CCR):

1. Do you wish to claim CCB as a reduction in your weekly fee? Yes No
2. Do you wish to claim CCR as a reduction in your weekly fee? Yes No
3. Do you have a child attending this service who is also attending another approved child care service? Yes No
 Child: _____
4. Does your child have any siblings listed on the Assessment Notice who are attending another Long Day Care service, Family Day Care service or Outside School Hours Care service? Yes No
 Number of children: _____

Custody Arrangements:

Are there any court orders, parenting orders or parenting plans in place for your child/children? YES /NO
 (IF YES COPIES ARE REQUIRED)

Please provide any further details:

.....

Education and Care Services National Regulations Regulation 160 (3)(c)(d)

Emergency Contacts/Authorised Nominees

Emergency contacts and authorised nominees must be over 18yrs and different than parents/guardians. An emergency contact is a person who is notified of an emergency if any of the parent/guardian's cannot be immediately contacted. Authorised nominees can give consent to medical treatment, administration of medication, authorise an educator to take your child/ren outside the education and care service premises (eg on excursions) and deliver or collect your child/ren to or from the education and care service.

Education and Care Services National Regulations Regulation 160 (3)(b)(ii)(iii)(iv)(v)

Emergency Contact Details:	Emergency Contact Details:
Name:	Name:
Address:	Address:
Contact Number:	Contact Number:
Relationship to your child:	Relationship to your child:
Authorised Nominee:	Authorised Nominee Permission: (please tick)
Name:	<input type="checkbox"/> To deliver or collect my child/ren
Address:	<input type="checkbox"/> To give consent to medical treatment of my child/ren
	<input type="checkbox"/> To authorise administration of medication to my child/ren
Contact Number:	<input type="checkbox"/> To authorise an educator to take my child/ren outside the education and care service premises
Relationship to your child	
Authorised Nominee:	Authorised Nominee Permission: (please tick)
Name:	<input type="checkbox"/> To deliver or collect my child/ren
Address:	<input type="checkbox"/> To give consent to medical treatment of my child/ren
	<input type="checkbox"/> To authorise administration of medication to my child/ren
Contact Number:	<input type="checkbox"/> To authorise an educator to take my child/ren outside the education and care service premises
Relationship to your child	
Authorised Nominee:	Authorised Nominee Permission: (please tick)
Name:	<input type="checkbox"/> To deliver or collect my child/ren
Address:	<input type="checkbox"/> To give consent to medical treatment of my child/ren
	<input type="checkbox"/> To authorise administration of medication to my child/ren
Contact Number:	<input type="checkbox"/> To authorise an educator to take my child/ren outside the education and care service premises
Relationship to your child	
Authorised Nominee:	Authorised Nominee Permission: (please tick)
Name:	<input type="checkbox"/> To deliver or collect my child/ren
Address:	<input type="checkbox"/> To give consent to medical treatment of my child/ren
	<input type="checkbox"/> To authorise administration of medication to my child/ren
Contact Number:	<input type="checkbox"/> To authorise an educator to take my child/ren outside the education and care service premises
Relationship to your child	

Permissions

- I understand that any excursions requiring transport will require a parent permission form to be signed by me prior to the excursion. I am aware that staff will notify me in writing prior to these excursions taking place.
- I give permission for my child's first name and photo to be used for centre purposes and program documentation.
- I give permission for my child's first name and photo to be used for promotional material for the Catholic Education Office of Western Australia.
- I give permission for staff to administer medication to my child if I have provided written authority.
- I give permission for staff to apply sun cream to my child as per the centre sun protection policy. If my child has an allergy to a certain cream I understand that I am responsible for providing a safe brand for them to use while at the centre.
- I accept liability for any medical/ambulance expenses which may occur while my child is in care.
- I give permission for my child/children to watch PG movies. Movie titles will be displayed on the notice board.
- I give permission for my child/children to participate in any ongoing incursions within the school grounds such as going to the library, playground or other areas when sharing our licensed space with the school. On occasion we may also share our licensed space with the school during annual school events.

Parent / Guardian Name: Date:

Signature:

Parent / Guardian Name: Date:

Signature:

Privacy Statement

Our service maintains records on attendance, fee payment, development and health of each child and family. This enables us to meet all of our legislative and regulatory responsibilities. Information provided by you for this purpose will be treated respectfully and confidentially. All personal information is kept in a secure place to protect it from unauthorised access, modification or disclosure. Only authorised staff that directly requires your information for professional purposes will have access to it. Families are able to access their information upon request.

Failure to provide the required information may result in non-acceptance of your child's enrolment.

Declaration

I/We hereby declare that all the information given is accurate and agree to abide by the conditions of the enrolment at the Xavier Outside School Hours Care Centre.

Parent/Guardian Name:Date:

Signature:

Parent/Guardian Name:Date:

Signature:

Registration Agreement

1. I have received and read the Family Handbook and Parents Policy Booklet and I understand any updates to policies will be displayed on the notice board or in the centre newsletter.
2. I understand that I need to comply with all Government requirements in relation to the Centre and its service.
3. I agree that in the case of accident or injury (other than minor incidents), the centre will contact me. If they cannot reach me they will try to contact someone else on my enrolment form. If determined necessary by the approved provider, nominated supervisor or an educator at the centre, I authorise staff to seek medical treatment for my child, from a registered medical practitioner, hospital or ambulance service. I authorise the approved provider, nominated supervisor or an educator to seek transportation of my child by an ambulance service and agree to meet any expenses incurred.
4. I understand that it is my responsibility to fulfil any obligations required to receive Child Care Benefit (CCB).
5. I will advise the Centre as soon as practicable of any updates to my circumstances.
6. I agree to pay my fees fortnightly unless arrangements have been made as determined by the fee payment policy.
7. I am aware that any failure to pay fees may result in cancellation of my child's place at the centre.
8. I am aware that fees will be reviewed annually and I will receive a minimum of two (2) weeks notice of any changes being made.
9. I am aware that two week's notice is required for cessation of care.
10. I am aware that I must pay for any public holidays that fall on a day my child is booked to attend. I will also be responsible for payment on any days my child is on holidays, sick or absent from care.
11. I understand that a system of payment for late collection operates at the centre and that I am responsible for the payment of any fees incurred.
12. I am aware that my child will be excluded from care at the centre if they have a communicable disease. I understand that my child will be accepted back into the centre once the exclusion guidelines have been met.
13. I consent to my child being in the presence of volunteers, visitors and students with due notice given, with the appropriate supervision by centre staff.
14. I have presented the centre with a copy of my child's current immunisation details and birth certificate.
15. I have read and understand the Privacy Statement.
16. The Centre reserves the right to cancel care if it considers doing so would be in the best interest of the Centre. Two weeks' notice of cancellation of care will be provided and any outstanding fee credits reimbursed upon conclusion of care at the centre.

I have read the registration agreement and agree to adhere to the above conditions and policies.

Parent/Guardian Name: Date:

Signature:

I have read the registration agreement and agree to adhere to the above conditions and policies.

Parent/Guardian Name: Date:

Signature:

Xavier OSHC Supervising Officer: Date:

Signature:

Birth Certificate provided

Immunisation Record provided