



St Thomas More OSHC Enrolment Form

Before School Care After School Care and Vacation Care

Attendance is for school aged children between 4 years and 13 years of age. Our current enrolments are inclusive of St Thomas More Primary School and Elizabeth Park Primary School and Vacation Care is open to the wider community.

Service Information:

Before School Care: 6:30am-8:30am

After School Care: 3:00pm-6:00pm (Wednesday 2:30pm-6:00pm)

Vacation Care: 6:30am-6:00pm

Nominated supervisor: Christopher Platten - St Thomas More School Principal

Service Director: Kate Thede

Approved Provider: Catholic Education South Australia

Contact Details:

50 Yorktown Road, Elizabeth Park. S.A. 5113

P.O. Box, 2002, Elizabeth Park. S.A. 5113

Telephone: 72851555

Mobile: 0409551699

Email: oshc@sttmore.catholic.edu.au

Checklist for families:

To enrol your child you must ensure the following:

- You have thoroughly read and understood the family handbook
 - Completed the enrolment package/forms
- Supplied Medical Health Plans (if applicable for each child)
 - Supplied Dietary Plans (if applicable for each child)
 - Supplied Official Diagnosis (if applicable for each child)
- Completed a Direct Debit Authority and or Centrepay Authority form
 - Completed an All About Me form, for each child
- Contacted Centrelink if you wish to apply for Child Care Subsidy on **(13 61 50)**
- Arranged with the Director to have an interview where you will submit your enrolment forms and discuss all relevant additional documentation or information, for each enrolled child



Who's Attending			
Information	Child A	Child B	Child C
Family Name:			
Child's Name:			
CRN:			
DOB:			
M/F:			
School Attending & Classroom Number/Teacher			

BOOKING INFORMATION

Background			
Are any of the children being enrolled of Aboriginal or Torres Strait Islander Background?			
Child A	Y/N	Child B	Y/N
Are any of the children being enrolled from a non-English speaking background?			
Child A	Y/N	Child B	Y/N
What is the cultural background of your child?			
Child A	Y/N	Child B	Y/N
Custody/Access details			
Are there any family court orders? If so please include a copy.			
Child A	Y/N	Child B	Y/N

Bookings	
<p>Please note any bookings that are not cancelled within 24 hours-notice may be charged the full attendance fee as an absence; unless a Professional Practice Doctor Certificate is supplied. Casual and extra bookings can be communicated with staff daily. Permanent care= If you require the same days every week, your child will be guaranteed a place on these days. Casual care= This suits those families whose routines change. Simply indicate to staff what bookings will be required.</p> <p><input type="checkbox"/> I require casual care</p> <p><input type="checkbox"/> I require permanent care(please indicate days on the table below)</p> <p>I would like to have my invoice: <input type="checkbox"/> emailed <input type="checkbox"/> posted <input type="checkbox"/> filed for pickup at OSHC</p>	

Child A	Monday	Tuesday	Wednesday	Thursday	Friday
Before School Care					
After School Care					
Child B	Monday	Tuesday	Wednesday	Thursday	Friday
Before School Care					
After School Care					
Child C	Monday	Tuesday	Wednesday	Thursday	Friday
Before School Care					
After School Care					



PARENT/CAREGIVER INFORMATION

Information	Parent/Caregiver 1	Parent/Caregiver 2
Family Name:		
Parent/Caregiver Name:		
Relationship to child:		
Mobile:		
D.O.B:		
CRN:		
Address:		
Email:		
Occupation: Address:		
Contact no:		
Is English your first language? If not please specify?	Y/N	Y/N
Are you of Aboriginal or Torres Strait Islander background?	Y/N	Y/N

Emergency contacts (other than primary carers)

Information	Contact 1	Contact 2
Full Name:		
Relationship to child:		
Contact number:		
Address:		

Authorised pickup

Emergency contacts will be contacted if primary caregivers are not available and are authorised to sign your children in and out of the centre; however if there is anyone else that is authorised to sign your child in and out of the service please list them here (we are not able to release your child to anyone not stated on this form.)

Full Name	Contact Number(s)



CONFIDENTIAL MEDICAL AND HEALTH INFORMATION (PER CHILD)

Family Name _____ Childs Name _____ DOB _____

Medical Diagnosis

* Does your child have a health care need that could affect their safety at Out of School Hours Care?

Condition	Yes	No	Condition	Yes	No
Anaphylaxis			Heart Disorder		
Seizures/Convulsions			Allergies		
Diabetes			Other		
Asthma					

Comments: _____

Health Support

* Does your child have:

Condition	Yes	No	Condition	Yes	No
Vision Impairment			Skin conditions (eg dermatitis)		
Joint Disorder (eg arthritis)			Incontinence		
Ear Disorder (eg drainage tubes)			Other		
Hearing Impairment					

Comments: _____

Medication

* Does your child have any routine health care needs (eg: medication)?

- NO
- YES, please attach a **medication plan** from your doctor or treating health care professional.

Dietary Requirements

* Are there any special dietary requirements relating to your child?

Condition	Yes	No	Condition	Yes	No
Lactose Intolerant			Cultural		
Gluten Intolerant			Other		
Fructose Intolerant					

Comments: _____

Additional Support

* Has your child been diagnosed with:

Condition	Yes	No	Condition	Yes	No
ADHD			Communication Difficulties		
Autism			Other		
Sensory Processing Disorder					

Comments: _____



Special Aids

* Does your child need special aids or equipment? (eg glasses, hearing aids, callipers)

Comments: _____

ADDITIONAL MEDICAL INFORMATION

Doctor			
Name:			
Practice:			
Contact number:			
Have the children received all immunisations appropriate for his/her age? <u>This may affect your Centrelink ccs% should all immunisations not be up to date.</u>	A Y/N	B Y/N	C Y/N
Medical Administration			
I give permission for qualified employees of St Thomas More OSHC to administer correctly supplied medication to my child; and any treatment they see fit in the case of an accident or emergency. If for any reason I or my emergency contacts are not available St Thomas More staff will be authorised to consent to treatments or medical authorities on my behalf. <i>NOTE: Please supply the service with the required medications in original containers with the child's name clearly marked. The service must also be provided with a copy of the child's health action plan with the medication.</i>	A Y/N	B Y/N	C Y/N
Medicare Details			
Medicare number:	Valid to:		
Reference Number- Child A:	Child B:	Child C:	

CONSENT FORM

<u>Child Information-</u> I give permission for oshc staff to exchange information relating to my child/ren with other persons that are appropriate to reason e.g. emergency personnel.	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>
<u>Policies-</u> I understand that it is my responsibility to become familiar with policies and procedures of the oshc service. All policies are available for viewing should I request.	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>
<u>Parent Handbook-</u> I have received read and understood the OSHC Parent Handbook including the Sun Protection Policy. I agree to abide by the information, fees and policies outlined within this handbook, I understand that my children are to be signed in and out of the service every session.	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>
<u>Code of behaviour-</u> I have read the Code of Behaviour (parent handbook) and agree to abide by the guidelines. I have informed my child/ren of the guidelines and take responsibility for them abiding by the guidelines. I understand that there are consequences for not following the Code of Behaviour and that the positive strategies that are outlined in the Code of Behaviour will be implemented if my child/ren is in breach of the guidelines.	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>
<u>Privacy Acknowledgement-</u> I acknowledge the information provided herein by me is to be used for the sole purpose of providing quality childcare services and that the information will only be released when legally required to do so. I understand that full disclosure of any additional needs for my child/ren is necessary.	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>
<u>Absences-</u> I agree to inform staff of any absence of my child/ren as soon as possible and understand that there may be fees included. I also agree to keep my child from attending the service if they are diagnosed with an infectious/contagious disease by a medical professional.	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>
<u>Observations/Photography-</u> I give permission for staff to observe my child/ren and record or photograph them for programming, documenting and school newsletter purposes.	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>



St Thomas More OSHC Enrolment Form

Sun Protection- I give permission for my child/ren to have a 30+ sunscreen applied as per the service’s Sun Smart Policy and understand that the “No Hat No Play” policy is implemented at the director’s discretion.	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>
Electronic devices- I understand that electronic devices, mobiles, ipads etc. are not to be brought into OSHC unless on a programmed day which I will be notified of.	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>
Movies- I give consent for my child/ren to watch G and PG films deemed appropriate by staff either in the service or on excursions.	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>
Hairspray/Face painting- I consent to my child to have their hair styled and face painted on both days programmed or through spontaneous play.	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>
General sport- I give permission for my child/ren to participate in programmed activities and team sports. I understand that some of these activities may be emotionally and physically demanding, however participation is voluntary and employees will exercise their duty of care through these activities to the best of their capabilities.	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>
Medical attention- I give permission for ambulance, medical, hospital or dental assistance in an emergency, and will cover the incurred costs. I also consent to all staff to act as necessary in the case of an accident. E.g., bumps, falls, scratches and toileting assistance whilst in St Thomas More OSHC care.	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>

DISCLAIMER

The St Thomas More OSHC uses the Enrolment Forms to collect personal information for the purposes of service enrolment and statistical recording. The information may be shared with funding agencies and administrators for operational purposes only.

The information will not be disclosed to any other party except as required by law. You are able to amend or correct information on request, by contacting the Service Director, which you will be informed to confirm in writing.

I/We _____ Person/s with lawful authority of children A _____
B _____ C _____ hereby give permission for the named children to attend St Thomas More OSHC and:

- Agree to abide by their policies relating to opening hours, signing in and out of children, sickness, payment of fees, late payment of fees and suspension due to program/safety disruptions.
- Declare that the information in this enrolment form is true and correct and undertake to immediately inform the OSHC service in writing in the event of any change to this information.
- Agree to collect or make arrangement for the collection of the child/ren, if they become unwell or needed to be collected for other reasons as per the discretion of the service leadership.
- Accept full responsibility of my child/ren’s belongings whilst attending the service.

Parent/Caregiver Name, Signature/s and Date.

Name: _____ Signature: _____ Date: _____

Name: _____ Signature: _____ Date: _____



ALL ABOUT ME

Questions	Child A	Child B	Child C
Favourite Food			
Most admirable qualities			
What I would like to do at oshc			
Excursions I would like to go on at oshc			
Favourite thing to do indoors			
To relax I like to			
Favourite thing to do outdoors			
Does your child/ren prefer to work/play in groups or individually			
What cultural or religious holidays do you celebrate at home?			
Does your family speak any other languages other than English at home?			
Is there any other information about your child/ren or family we should know to better cater to your needs?			



CENTREPAY FORM

I authorise the Department of Human Services to make a Deduction from my payments to pay this amount to St Thomas More School, CRN 555-060-380-B.

Customer Name: _____

Customer CRN: _____

Customer Date of Birth: _____

Customer Contact Number: _____

Deduction Amount : \$ _____

Frequency: Fortnightly/Weekly (please circle)

Payment Type: _____

(e.g. Age Pension, Newstart Allowance, Family Tax Benefit or parental leave pay)

Commencement Date: _____

Option 1:

I request that this deduction continues until the target amount is reached.

Target Amount: \$ _____

Option 2:

I request that this deduction continue until the date is reached.

Date of completion: _____

I give permission for St Thomas More School to give the Department of Human Services my correct account and billing number if required.

I understand that I can change or cancel my Deduction at any time; and further information about Centrepay can be found online at humanservices.gov.au/centrepay.

Customer Signature: _____

Date: _____

Office Use:

Customer Civica reference Number: _____

Date Entered: _____



St Thomas More School Direct Debit Request Form

Request and Authority to debit the account named below to pay Catholic Church Endowment Society Inc

Surname:	
Given Name:	
Financial Institute Name:	
Suburb:	
Account Name:	
Account Details:	BSB: _____ - _____ Account Number: _____
Payment Details:	First Debit to be made on ____/____/____
Payment Amount:	\$_____ and at Weekly/Fortnightly/Monthly/Half Yearly intervals
Payment Completion:	This authority will remain in place until ____/____/____ <i>or</i> Written request to cancel/suspend payments is provided by you
Signature:	
Address:	
Contact Number:	
Email:	
Date:	
Child's Name:	

By signing this Direct Debit Request you acknowledge having read and understood the terms and conditions governing the debit arrangements between you and Catholic Church Endowment Society Inc as set out in this Request and in your Direct Debit Request Service Agreement.

Office Use Only

Family Code:	Civica Number: _____ Bpay Number: 9023 _____
Entered:	Date Entered: _____ Signature: _____



CONFIDENTIAL MEDICAL AND HEALTH INFORMATION (PER CHILD)

Family Name _____ Childs Name _____ DOB _____

Medical Diagnosis

* Does your child have a health care need that could affect their safety at Out of School Hours Care?

Condition	Yes	No	Condition	Yes	No
Anaphylaxis			Heart Disorder		
Seizures/Convulsions			Allergies		
Diabetes			Other		
Asthma					

Comments: _____

Health Support

* Does your child have:

Condition	Yes	No	Condition	Yes	No
Vision Impairment			Skin conditions (eg dermatitis)		
Joint Disorder (eg arthritis)			Incontinence		
Ear Disorder (eg drainage tubes)			Other		
Hearing Impairment					

Comments: _____

Medication

* Does your child have any routine health care needs (eg: medication)?

- NO
- YES, please attach a **medication plan** from your doctor or treating health care professional.

Dietary Requirements

* Are there any special dietary requirements relating to your child?

Condition	Yes	No	Condition	Yes	No
Lactose Intolerant			Cultural		
Gluten Intolerant			Other		
Fructose Intolerant					

Comments: _____

Additional Support

* Has your child been diagnosed with:

Condition	Yes	No	Condition	Yes	No
ADHD			Communication Difficulties		
Autism			Other		
Sensory Processing Disorder					

Comments: _____



Special Aids

* Does your child need special aids or equipment? (eg glasses, hearing aids, callipers)

Comments: _____



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