

## **Magill School OSHC**

Adelaide Street, Magill SA 5072 Ph: 8332 5762 mpsoshc@chariot.net.au

## **OSHC Enrolment Form**

Child 1	Chi	ld 2	Child 3
Family Name:	Family Name:		Family Name:
Given Names:	Given Names:		Given Names:
Date of Birth:	Date of Birth:		Date of Birth:
Gender: Male□/Female□	Gender: Male	]/Female□	Gender: Male□/Female□
CRN:	CRN:		CRN:
Aboriginal/Torres Strait Islander: Y□/N□	Aboriginal/Torres St Y□/		Aboriginal/Torres Strait Islander: Y□/N□
Home Address:			
Suburb:			Postcode:
	Enrolling Pare	ent/Guardian	
Name:			
Date of Birth:	CRN:		Relationship to Child/ren:
Address:			
Suburb:			Postcode:
Home Phone:	Work Phone:		Mobile:
Email:			
Ot	her Parent/Guar	dian (if applicab	ole)
Name:		Relationship to 0	Child/ren:
Address:			
Suburb:			Postcode
Home Phone:	Work Phone:		Mobile:
Email:			

Parenting Plans/Orders relating to these children: (please attach relevant information/plans etc.)					
_			••		
It is very important that you tell these peopl child's behalf if neither parent can be contacte		minating	them y	ou give them author	
Name:				✓ if ap	plicable
Address:				Emergency Co	ontact: 🗆
				Collection Au	thority: 🛘
Suburb:	Postcode:		0.1		9.17
Phone:	Mobile:		Reia	ationship to chi	ııa/ren:
Name:				✓ if ap	plicable
Address:				Emergency Co	ontact∙ □
				Collection Au	
Suburb:	Postcode:				
Phone:	Mobile:		Rela	ationship to chi	ild/ren:
Name:			•	✓ if ap	plicable
Address:				Emergency Co	ontact: 🗆
				Collection Au	thority: $\square$
Suburb:	Postcode:		Dala	-+:	ild/non.
Phone:	Mobile:		кега	ationship to chi	na/ren:
Name:				√ if ap	plicable
Address:				Emergency Co	ontact: 🗆
				Collection Au	thority: $\square$
Suburb:	Postcode: Mobile:		Dola	ationship to shi	ild/ron.
Phone:	Mobile:		Keia	ationship to chi	na/ren:
	Medical & Health Inform	ation			
Has the child received all immunise	ations appropriate for	Child		Child 2	Child 3
his/her age?	Idea and the second and a second	Y□/		Y□/N□	Y□/N□
I accept full responsibility if my chi my doctor.	id is not immunised and agre	ee to pi	roviae	e an exemptior	i letter from
Parent/Guardian S	iignature:				
Has the child any conditions/media		Child		Child 2	Child 3
·		Y□/	N	Y□/N□	Y□/N□
Please provide details:					
Has the child an special needs or di	isahilities?	Child	1	Child 2	Child 3
the sima an opecial fields of a		Y□/		YD/ND	Y   N
Please provide details:				· ·	•

Has the child any special dietary needs not relating to allergies?			Child 1 Y□/N□	Child 2 Y□/N□	Child 3 Y□/N□
Please provide details:			T I I I I I I I I I I I I I I I I I I I	TU/NU	TU/NU
Has the child any kind of allergies?			Child 1	Child 2	Child 3
E.g. Foods - Reaction & medication			Y□/N□	Y□/N□	Y□/N□
Please provide details:					
Has the child any other medical information we might need to			Child 1	Child 2	Child 3
know?			Y□/N□	Y□/N□	Y□/N□
Please provide details:					
Please supply the service with re Please also provide a medical					
r lease also provide a medicar	actioi	asthma, anaphylaxis etc.	alcation for in	e tilleaterillig li	inesses e.g.
Usual Medical Attendant	Do	ctors Name:			
Phone:		Clinic Name			
Address:					
	_	Suburb:		Postcode:	
Usual Dental Attendant	Do	ctors Name:			
Phone:		Clinic Name:			
Address					
Address:		Suburb:		Postcode:	
Medical Benefits Cover with:					
Ambulance Cover with:					
Medicare Number:					
Health Care Card Number:					
riculti care cara ivanisci.					
Any other Information					

Consents		Initial			
I consent for my child/ren to take part in supervised walking excuas part of the Centre's program.	rsions within the local area				
I consent for my child/ren to be photographed and for their image and name to be displayed only at Magill OSHC.					
I consent for a staff member to apply sun screen to my child/ren	if required.				
I give permission for OSHC staff to exchange information relating to my child/ren with school staff. I understand this will be handled confidentially. e.g. Emergency situation.					
In an emergency situation which requires immediate medical attention I understand that the Ambulance will be called prior to contacting the parents/ guardians. I give permission					
for medication to be administered to my child under instructions from the emergency response officers. Parents/guardians will be contacted as soon as possible.					
Agreements					
I agree to pay the required fees for my child/ren's booked hours a the service.	and accept the policies and ru	ules of			
I agree that the staff of the service may administer simple first aid	d to my child if the need arise	!S.			
I understand that if at any time the staff of the service consider the medical/hospital/ambulance assistance, they will have the local remy child. I acknowledge that I will be liable for any medical/hospithe treatment of my child.	medical/hospital/ambulance	attend to			
I certify that the information entered upon this form is true to the undertake to inform the service if any of these details change.	e best of my knowledge and I				
Parent/Guardian Signature	Date				