



**ST ANTHONY'S**  
PARISH PRIMARY SCHOOL



Date Received

Court Orders

Medical Action Plan

## **St Anthony's Primary Out of School Care Activities (OOSCA)**

In accordance with Catholic Education Enrolment Policy and Regulations

# **2016 Enrolment Form**

Family Name	
Child 1	
School	
Child 2	
School	
Child 3	
School	

### **Billing Information**

Accounts are emailed every fortnight. Please nominate your preferred email address here:

Email:	
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Please ensure that you and/or your partner have completed all the sections and questions you need to answer and have signed and dated where necessary.

If you have any questions about this form, please contact  
**St Anthony's Primary Out of School Care Activities (OOSCA)**

161 Wheeler Crescent, Wanniasa ACT 2903

Ph: 6296 2261

Necta Gianakis, Director: Mobile: 0499 161 456

Email: [oosca@cg.catholic.edu.au](mailto:oosca@cg.catholic.edu.au)

Enrolment Forms need to be updated annually.

Booking forms for Vacation Care will need to be completed for each program.

Staff use only:

	Enrolment form dated on receipt	Signature:	Date:
	All relevant attachments received	Signature:	Date:
	CRN details completed	Signature:	Date:
	Billing email supplied	Signature:	Date:
	Details updated/created on Qikkids	Signature:	Date:

## Parent A

Given name:  Family name:

Date of Birth:  CRN: (to claim CCB & CCR)

Are you the parent that receives the Family Assistance Office Child Care Benefit (CCB) and Child Care Rebate (CCR)?(Please tick) Yes  No

Relationship to child/ren:  Mother  Father  Other (Please specify)

Street address:

Suburb:  State:  Postcode:

Home Phone:  Mobile phone:

Work Phone:  Email:

Work Status: (please tick)

Full time employment  Part time employment  Actively seeking employment

Studying full time  Other (Please specify)

Occupation:  Employer:

Country of birth:  Religion:

Other languages spoken at home? (other than English)

Are you of Aboriginal or Torres Strait Islander Background? (Please tick) Yes  No

## Parent B

Given name:  Family name:

Date of Birth:  CRN: (to claim CCB & CCR)

Are you the parent that receives the Family Assistance Office Child Care Benefit (CCB) and Child Care Rebate (CCR)?(Please tick) Yes  No

Relationship to child/ren:  Mother  Father  Other (Please specify)

Street address:

Suburb:  State:  Postcode:

Home Phone:  Mobile phone:

Work Phone:  Email:

Work Status: (please tick)

Full time employment  Part time employment  Actively seeking employment

Studying full time  Other (Please specify)

Occupation:  Employer:

Country of birth:  Religion:

Other languages spoken at home? (other than English)

Are you of Aboriginal or Torres Strait Islander Background? (Please tick) Yes  No

## Emergency Contacts

### Emergency Contact 1: (Other than Parent's listed previously)

Given name:  Family name:

Street address:

Suburb:  State:  Postcode:

Home Phone:  Mobile Phone:

Work Phone:  Relationship to child/ren:

Is this person authorised to collect the child/ren from care? (Please tick) Yes  No

Is this person authorised to consent to medical treatment? Yes  No

### Emergency Contact 2: (Other than Parent's listed previously)

Given name:  Family name:

Street address:

Suburb:  State:  Postcode:

Home Phone:  Mobile Phone:

Work Phone:  Relationship to child/ren:

Is this person authorised to collect the child/ren from care? (Please tick) Yes  No

Is this person authorised to consent to medical treatment? Yes  No

## Other People Authorised To Collect the Child

### Contact 1

Given name:  Family name:

Street address:

Suburb:  State:  Postcode:

Home Phone:  Mobile Phone:

Work Phone:  Relationship to child/ren:

### Contact 2

Given name:  Family name:

Street address:

Suburb:  State:  Postcode:

Home Phone:  Mobile Phone:

Work Phone:  Relationship to child/ren:

### Contact 3

Given name:  Family name:

Street address:

Suburb:  State:  Postcode:

Home Phone:  Mobile Phone:

Work Phone:  Relationship to child/ren:

## Doctor's Details

Doctor's name:

Street address:

Suburb:  State:  Postcode:

Phone:  Medicare Number:

## Other Children in Approved Care

Please supply details of any other children in approved care (to claim CCB & CCR)

Given Name	Family Name	Date of Birth	Sex

## Authorisations and Conditions of Care

### Medical Treatment Permission

I give permission for the staff to give first aid treatment in the event of minor injuries to my child.

In the event of an accident or serious illness regarding my child I give permission for staff to seek medical attention or arrange ambulance transport to the hospital if considered necessary for the welfare and safety of my child. I understand that I will be required to pay for any costs associated with transport and/or treatment of my child.

I understand that the centre is unable to care for sick children or children with contagious illness. The centre reserves the right to exclude any child not well enough to cope with planned activities and will contact parents to arrange collection of their child

Signature:

### Fees Consent:

I/we agree to make regular payments and finalise the account before the end of each term. Care may be cancelled if accounts are overdue according to the Centre Policy. I/we understand that in the event of financial hardship, application may be made to the Centre Finance Officer for consideration of special arrangements. Otherwise, I/we understand that the centre is entitled to the recovery of outstanding fees.

Signature:

### Behaviour Guidelines:

I/We have read the Behaviour Management Policy and guidelines (see the Parent Handbook) and agree to abide by the guidelines. I/We have informed the child/ren of the guidelines and take responsibility for them abiding by the guidelines. I/We understand that there are consequences for not following these guidelines and the strategies that are outlined in the Behaviour Management Policy will be implemented if the child/ren is in breach of the guidelines.

Signature:

### Privacy:

I/We understand the service protects the confidentiality and privacy of individuals by ensuring records about individual children and families are kept in a secure place and only accessed by or disclosed to those people who need the information to fulfil their responsibilities at the service or have a legal right to know.

Signature:

# Child 1

## Details:

Child's name:  Family name:

Date of Birth:  Sex: Male  Female

Child's CRN: (to claim CCB & CCR)  Year Level in 2016:

Street address:

Suburb:  State:  Postcode:

What country was this child born in?

What languages does this child speak at home? (other than English)

Is this child of Aboriginal or Torres Strait Islander Background? (Please tick) Yes  No

Please tick if this child is:

- From a culturally and linguistically diverse background
- From a refugee background who has been subjected to trauma
- In the care of the state or other forms of out of home care
- If this place has been sought by a state or territory child protection worker

## Immunisation:

Is this child immunised? (Please tick) Yes  No

## Court Orders:

Is this child involved in a court order, parenting order or parenting plan?  
(Please tick) Yes  No

**If yes, please supply a copy (to be enforced documents must be provided)**

Is this child involved in a court order relating to the child's residence? Yes  No

**If yes, please supply a copy (to be enforced documents must be provided)**

Is this child involved in a court order relating to the child's contact with a parent or other person? Yes  No

**If yes, please supply a copy (to be enforced documents must be provided)**

## Medical Information:

Has this child been diagnosed with a medical condition? Eg. Asthma, seizures, allergies, anaphylaxis, etc. (Please tick and give details) Yes  No

**If yes, please supply a current medical action plan form (if required)**

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## Dietary Requirements:

Are there any specific dietary requirements for your child?  
(Please tick and give details) Yes  No

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**Please fill out a medical form for any dietary or medical condition  
(enclosed in enrolment pack)**

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**Additional Needs:**

Has this child been diagnosed with a disability or additional needs or is undergoing any diagnosis (Please tick and give details) Yes  No

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**Cultural or Religious Requirements:**

Are there any specific cultural or religious requirements for your child? (Please tick and give details) Yes  No

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**Fears or Phobias:**

Does this child suffer from fears or phobias? (Please tick and give details) Yes  No

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**Interests and Hobbies:**

What are the child's interests and hobbies? Eg. Sports, drawing, cooking, board games, reading, etc

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**Consents**

Do you give permission for this child to have their face painted? Yes  No

Do you give permission for this child to have their hair sprayed? Yes  No

Do you give permission for this child to be photographed or videoed for the purposes of displaying in the service? Yes  No

Do you give permission for this child to be photographed or recorded for the purposes of documenting yours and other children's learning at OOSCA? Yes  No

Do you give permission for this child to watch PG rated programs (TV, DVD, movies) and play PG rated computer games? Yes  No

Do you give permission for this child to participate in short excursions away from the centre within the surrounding suburbs eg. Local Parks? Yes  No

Please sign below to acknowledge that you understand the consents you have ticked above

Signature:

**Bookings: Please circle Weekly / Fortnightly / Casual Starting Date: \_\_\_\_\_**

Please tick the days/sessions you would like your child to attend OOSCA.

Week 1	Monday	Tuesday	Wednesday	Thursday	Friday
BSC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ASC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Week 2	Monday	Tuesday	Wednesday	Thursday	Friday
BSC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ASC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Child 2

### Details:

Child's name:  Family name:

Date of Birth:  Sex: Male  Female

Child's CRN: (to claim CCB & CCR)  Year Level in 2016:

Street address:

Suburb:  State:  Postcode:

What country was this child born in?

What languages does this child speak at home? (other than English)

Is this child of Aboriginal or Torres Strait Islander Background? (Please tick) Yes  No

Please tick if this child is:

- From a culturally and linguistically diverse background
- From a refugee background who has been subjected to trauma
- In the care of the state or other forms of out of home care
- If this place has been sought by a state or territory child protection worker

### Immunisation:

Is this child immunised? (Please tick) Yes  No

### Court Orders:

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**If yes, please supply a copy (to be enforced documents must be provided)**

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### Medical Information:

Has this child been diagnosed with a medical condition? Eg. Asthma, seizures, allergies, anaphylaxis, etc. (Please tick and give details) Yes  No

**If yes, please supply a current medical action plan form (if required)**

### Dietary Requirements:

Are there any specific dietary requirements for your child?  
(Please tick and give details) Yes  No

**Please fill out a medical form for any dietary or medical condition  
(enclosed in enrolment pack)**

**Additional Needs:**

Has this child been diagnosed with a disability or additional needs or is undergoing any diagnosis (Please tick and give details) Yes  No

**Cultural or Religious Requirements:**

Are there any specific cultural or religious requirements for your child? (Please tick and give details) Yes  No

**Fears or Phobias:**

Does this child suffer from fears or phobias? (Please tick and give details) Yes  No

**Interests and Hobbies:**

What are the child’s interests and hobbies? Eg. Sports, drawing, cooking, board games, reading, etc

**Consents**

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ASC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Week 2	Monday	Tuesday	Wednesday	Thursday	Friday
BSC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ASC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>