# Prospect Primary School – Out of School Hours Care

*Enrolment Form*

27 Gladstone Road, Prospect, SA 5082 0456 966 460 oshc.PPS87@schools.sa.edu.au

| **Child** | | | | | |
|---|---|---|---|---|---|
| Family Name: | | | | Gender: | M F |
| First Name(s): | | | Known as: | | |
| Date of birth: | / / | | CRN: | | |
| Address: St no. | | | Suburb: | | |
| Postcode: | | Primary Language: | | | |
| Aboriginal: | | | TS Islander: | | |
| School: | | | | | |

| **PARENTING PLANS/ORDERS relating to this child** |
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| **Enrolling Parent/Guardian and Billing Details** | | | | | |
|---|---|---|---|---|---|
| Name: | | | | | |
| Date of birth: | / / | | CRN: | | |
| Relationship to child: | | | Contact priority: | | |
| Address: St no. | | | Suburb: | | |
| Postcode: | | Primary Language: | | | |
| Phone: | m: | | h: | | w: |
| Email: | | | | | |
| | | | | | |
| **Other parent/guardian** (If applicable) | | | | | |
| Name: | | | | | |
| Relationship to child: | | Contact priority: | | Primary language: | |
| Address: | | | | | |
| Phone | m:<br>h: | | w: | | |

| **Emergency Contacts and Collection Authorities** | | | |
|---|---|---|---|
| Name: | | | |
| Address: | | | |
| Phone: | m:<br>h: | w: | |
| Relationship to child: | | Contact priority: | |
| | | | |
| Name: | | | |
| Address: | | | |
| Phone: | m:<br>h: | w: | |
| Relationship to child: | | Contact priority: | |
| | | | |
| | | | |

## Medical and Health Information

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|---|---|
| Has the child received all immunisations appropriate for his/her age? | Yes / No |
| If no, please give details: | |

Has the child received the following immunisations?

| | 10 – 13 years | 12 – 18 years |
|---|---|---|
| Hepatitis B | ☐ | ☐ |
| Varicella (chickenpox) | ☐ | ☐ |
| Human Papillomavirus (HPV) | ☐ | ☐ |

I accept full responsibility if my child is not immunised:

| | |
|---|---|
| Parent/guardian signature: | |

| | |
|---|---|
| Has the child any medical conditions that may be affected by OSHC activities? | |
| If yes, please give details: | |
| Has the child any disabilities? | Yes / No |
| If yes, please give detail: | |
| Has the child any special needs? | Yes / No |
| If yes, please give detail: | |
| Has the child any special dietary needs? | Yes / No |
| If yes, please give detail: | |

Has the child any kind of allergic reactions?

| Foods: | Reaction/medication: |
|---|---|
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| | |
| | |
| Other: | Reaction/Medication: |
| | |
| | |

Is there any other medical information we might need to know?

**Note:** Please supply the service with required medications in original containers with the child's name clearly marked. Please complete a permission to administer medication form together with any medication records where necessary.

**Usual Medical Attendant:**

| | | | |
|---|---|---|---|
| Doctors name: | | Phone: | |
| Clinics name: | | | |
| Address: | | | |

| | | |
|---|---|---|
| Medical Benefits cover with: | | |
| Ambulance cover with: | | |
| Medicare number: | | |
| Health care card number: | | |
| | | |
| **Consents:** | | |

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|---|---|
| I give consent for my child to use service provided sunscreen | |
| Parent/guardian signature: | |
| I give consent for my child to attend local excursions as part of the OSHC program | |
| Parent/guardian signature: | |
| I give my permission for staff to transport my child to the local hospital in circumstances that deem it necessary for my child's health and safety | |
| Parent/guardian signature: | |
| I give consent for my child to appear in photographs taken at the service for school purposes | |
| Parent/guardian signature: | |
| I give consent for my child to watch PG rated movies and DVDs at the service | |
| Parent/guardian signature: | |