CHAMPS OSHC
ENROLMENT FORM

Completing This Form:

- **Please complete an Enrolment Form for each child enrolling at CHAMPS OSHC COLAC VIC Service**
- **All sections of the form must be completed**
- **This form must be completed by a Parent or Guardian who has lawful authority in relation to the child**
- **Please inform all parties that personal details and information you have provided will be stored by CHAMPS OSHC COLAC VIC**
- **All information required by the Service MUST be provided by the family prior to your child's attendance (the Service reserves the right to refuse care to any family that does not provide all relevant information and medical documentation)**

Child details

First Name: …….. **Family Name:** ……

Gender: ☐ **Male** ☐**Female** **Date of Birth:** ……

Home Address: ……

Language/s Spoken at home: ……

Country of Birth: …….. **Child CRN:** ……..

Primary School: …… **Grade Level:** ……

Total Number of Children in Approved Care: …… **(include children attending other centres)**

Parent/Guardian #1 Details (person responsible for payment of fees)

First Name: …….. **Family Name:** ……

Gender: ☐ Male ☐Female **Date of Birth:** ……

Relationship to child?: ……

Home Address ☐ **(as per child) Or:** ……..……

Language/s Spoken at home: ……

Country of Birth: ……..**CRN:** ……..

Phone Number: …… **Mobile:** ……..……

Work Phone: …… **E-mail:** ……..

Does the child live with this person? ☐ Yes ☐ No (please tick)

Parent/Guardian #2 Details ☐ N/A (or)

First Name: …… **Family Name:** ……

Gender: ☐ Male ☐ Female **Date of Birth:** ……

Relationship to child?: ……

Home Address ☐ **(as per child) Or:** ……

Language/s Spoken at home: ……

Country of Birth: ……..**CRN:** ……..

Phone Number: …… **Mobile:** ……

Work Phone: …… **E-mail:** ……..

Does the child live with this person? ☐ Yes ☐ No (please tick)

Custody of Child

Which days does the child live with Parent/Guardian #1?

☐ N/A ☐ Permanently (or)

From day: _____time_____ *To* day:_____time_____

Which days does the child live with Parent/Guardian #2?

☐ N/A ☐ Permanently (or)

From day: _____time_____ *To* day:_____time_____

Custody access details ☐ N/A (or)

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Court Orders

Are there any court orders relating to the powers and responsibilities of the parents in relation to the child or access to the child?

☐ No (go to the next section)
☐ Yes Please attach a copy of the court order, and provide details of guardianship, custody and terms of specific access provisions. Please feel free to discuss your family situation with the Director of Programs as often as necessary

Permission to seek Medical Advice for child enrolled at CHAMPS OSHC COLAC VIC

In the event of a medical emergency, please contact:

Medical Practitioner: ……..……..

Medical Clinic: ……..……

Address: ……..……..

Phone No: ……. Ambulance Sub. No: …..……..

Medicare No. …… Child Ref ……..

☐ I hereby give authorization for the Approved Provider, Nominated Supervisor, or an Educator within the Service to provide basic first aid to, and/or seek medical treatment for this child from a registered medical practitioner, hospital or ambulance service. In the event of an emergency, I give my consent to the transportation of this child by an ambulance service.

Authority to Consent/Emergency Contacts/Authority to Collect

- At least two contact must be provided in this section
- Do not include Parent/Guardian names in this section
- All persons authorized to collect the child must be over 18 yrs of age
- Any person unknown to staff will be required to produce photo I.D

☐ I authorize the following person/s to consent to medical treatment of, or to authorize administration of medication to this child. This person/s may also authorize an educator to take this child outside of the premises. I authorize this person/s to collect this child from CHAMPS OSHC COLAC VIC Service, and may also be notified to collect the child in the event of an accident, illness, injury, natural disaster or trauma in cases where the parents/guardians cannot be contacted.

Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**
Mobile:	**Mobile:**
Relationship to child:	**Relationship to child:**

☐ I authorize the following person/s to collect this child from CHAMPS Service. I am aware that these people may also be notified to collect the child in the event of an accident, illness, injury, natural disaster or trauma in cases where the parents/guardians cannot be contacted.

Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**
Mobile:	**Mobile:**
Relationship to child:	**Relationship to child:**

Has the child received all of the recommended immunizations according to the National Health & Medical Record Council?

☐ Yes ☐ Copy provided
☐ No ☐ Exempt (please provide details)

Please note that children will be excluded from the program in the event of an outbreak of infectious disease unless relevant information is provided to the Service, or in cases where the child is not immunized.

Getting to know the Child

Please select one of the following:

☐ I know of no medical or other condition, circumstance or risk which this child has that may impact on, or adversely affect the child's involvement in any activity or program in which the child may participate (go to the next section)

☐ The child has one of the following medical conditions/additional needs/disabilities which may impact on their participation in a particular/any activity or program

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Does the child require regular medication?

☐ Yes (if yes, you will be required to fill out a medications form)
☐ No

Has the child been diagnosed as at risk of Anaphylaxis?

☐ Yes (please provide a current copy of their Anaphylaxis Management Plan signed by their Practitioner)
☐ Copy Attached
☐ No

(If Yes)

Does the child have an auto injection device? (e.g. an EPIPEN) ☐ Yes ☐ No
please note that an EPIPEN must be handed to staff on sign in

Has the child been diagnosed with Asthma?

☐ Yes (please provide a current copy of their Asthma Management Plan signed by their Practitioner)
☐ Copy Attached
☐ No

Has the child been diagnosed with Diabetes?

☐ Yes (please provide a copy of the Individual Health Care Plan signed by their Practitioner)
☐ Copy Attached
☐ No

Has the child been diagnosed with any other Medical Condition?

☐ Yes (please provide details)
☐ No

(Please provide a current copy of their Individual Health Care Plan signed by their Practitioner)

☐ Copy Attached

Does the child have specific dietary requirements?

☐ Yes (please provide details) ☐ No

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Please note that children will not be allowed to attend the Service unless all medical information has been provided and is current. A Risk Assessment and Communication plan must also be implemented by the Service in conjunction with families prior to the care and education of any child with a diagnosed Medical Condition. Please attach any additional information as necessary.

Other details

Is the child of Aboriginal or Torres Strait Islander Origin?

☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander
☐ No

Does the child have a disability?

☐ Yes (please provide details)
☐ No

Definition of a child with a disability:

Does this child have a need for additional assistance in any of the following areas, compared to children of a similar age, that is related to an underlying long-term (lasting more than 6 months) health condition or disability? Tick the appropriate boxes.

☐ Learning and applying knowledge, education
☐ Communication
☐ Interpersonal interactions and relationships
☐ Other - including general tasks, domestic life, community and social life
☐ Self Care
☐ Mobility
☐ Reading/Writing (if applicable to age)

The definition of a child with a disability does NOT include children with a medical condition for example, asthma, allergies, eczema; or a condition that is short term or episodic (lasts for 6 months or less) for example infectious diseases

Does the child have special needs?

☐ Yes (please provide details)
☐ No

Children with special needs are those from the priority groups below.
If Yes, please tick the appropriate boxes.

☐ Children from culturally and linguistically diverse background
☐ Children with a refugee background who have been subjected to trauma
☐ Indigenous children
☐ The child's place has been sought by a state or territory child protection worker
☐ The child is in the care of the state or other forms of out of home care

Does the child suffer from anxiety or fears?

☐ Yes (please provide details)
☐ No

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Does the child have siblings?

☐ Yes (please provide details)
☐ No

Name……Age……Living with child Yes/No

Name……Age……....Living with child Yes/No

Name……Age……Living with child Yes/No

Name……Age……Living with child Yes/No

Other information that might be helpful in the provision of care to the child

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Please feel free to discuss any aspects of care for the child with our staff

In some cases, there may be a waiting list for child care services and to ensure the system is fair, the Australian Government has "Priority of Access Guidelines" for allocating places in these circumstances.

- First Priority: a child at risk of serious abuse or neglect
- Second Priority: a child of a single parent who satisfies, or of parents who both satisfy, the work/training/study test under Section 14 of the *'A New Tax System (Family Ass) Act 1999*
- Third Priority: any other child

To assist us to determine your "need" for childcare support, in accordance with this access system, please indicate the following (tick all boxes that apply):

Parent/Guardian #1 activity:

☐ Working/Studying/Training full time
☐ Working/Studying/Training part time
☐ Volunteer (over 15 hrs per week)
☐ Looking for work
☐ Disability/Carer
☐ None of the above

Parent/Guardian #2 activity:

☐ Working/Studying/Training full time
☐ Working/Studying/Training part time
☐ Volunteer (over 15 hrs per week)
☐ Looking for work
☐ Disability/Carer
☐ None of the above

CHAMPS OSHC COLAC VIC is a non-denominational Service. We are happy to include, and where possible provide for children the opportunity to respect, recognize and celebrate their culture, whilst respecting the rights of all children in our Service

Please provide details of festivals/celebrations that your family recognizes

☐ Birthdays	☐ Mothers Day	☐ Fathers Day	☐ ANZAC Day
☐ Christmas	☐ Easter	☐ New Year	☐ Australia Day
☐ Lent	☐ Ramadan	☐ Halloween	☐ Chinese New Year

☐ National Day _____ celebrated on _____

☐ Independence Day _____ celebrated on_____

☐ Other_____ celebrated on _____

Additional information about the child's culture that may assist in their care

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I would be willing to share this information with other children/families at the Service

☐ Yes (please provide details – tick the appropriate box)
☐ No

☐ Books	☐ Artifacts	☐ Personal Stories	☐ Demonstration
☐ Cooking	☐ Songs	☐ Teaching Language	☐ Music

☐ Other ……..

Declarations and Consent

I, _____(Parent/Guardian) having lawful authority of the child referred to in this enrolment form, declare that the information that I have provided is true and correct, and understand that it is my responsibility to immediately inform CHAMPS OSHC COLAC VIC of any changes or updates to this information.

Medical and Health

I understand that it is my responsibility to provide CHAMPS OSHC COLAC VIC with all necessary information and up to date
medical documentation required in the provision of care to my child (i.e. individual health care plans) and to promptly advise CHAMPS OSHC COLAC VIC of any changes to medical issues or change to the legal authority with respect to the child, and that:

- In the case of an emergency, an ambulance will be called in the first instance
- In the event of an emergency, I consent for an ambulance to take my child to the hospital
- I understand that all medical and transport costs are payable by me and are my responsibility. I give my consent for the child's medical files to be released to the ambulance service and the admitting hospital
- I agree to inform the staff of all medical needs and requirements of the child. This includes information of any medical condition, medications required to be administered and/or any medications/substances that should not be provided to the child
- I understand that the staff may contact me and ask me to collect the child due to illness or as a result of an accident that may require further medical attention
- I agree to collect, or make arrangements for the collection of the child referred to in this enrolment form if he/she becomes unwell at the Service
- I understand that a doctor's certificate may be required to allow the child to return to the Service
- I agree to inform the Service of any illness my child contracts that may be detrimental to the health of others
- I agree that the ongoing management of my child's medical condition, if any, remains my sole responsibility and is not and does not under any circumstance become the responsibility of the Service or staff at CHAMPS OSHC COLAC VIC

Privacy

CHAMPS OSHC COLAC VIC acknowledges and respects the privacy of individuals. All information collected on the child's enrolment form and during the term of enrolment, including health and sensitive information, is collected, retained and used for the purpose of establishing and maintaining the child's enrolment and processing financial payments and benefits where applicable. By signing this enrolment, you agree that, to the extend reasonably necessary to enable provision of the child's enrolment and in conducting the Service, CHAMPS OSHC COLAC VIC , its staff, and outside service providers such as specialists, emergency care providers, financial institutions, Federal, State and Local Government Agencies covered by law, may be recipients of such information. You have the right to access and alter personal information about you and the child retained by CHAMPS OSHC COLAC VIC in accordance with the Privacy Act 1988. You will receive communication from time to time to update you on matters regarding the child's enrolment. CHAMPS OSHC COLAC VIC uses a variety of means of communication including mail, e-mail, phone and SMS. By providing contact details relating to any of these forms of communication, you consent to receiving communication by those means.

Parent/Guardian Name_____

Signature: _____**Date:**_____/_____/_____

I understand that this page will be copied and made available to staff at all times to ensure that my wishes in regards to the care of my child are followed throughout all Program activities

- I acknowledge that due to Children's Services Regulations requirements there may be times when the child's full name will be displayed at the Service, in records which include, but are not limited to: Sign In/Out Books, Incident Report Books, and Action Plans.
- I accept full responsibility for the child's belongings whilst taking part in the program
- I understand the Program offers Excursions/Incursions at an additional cost, which I authorize my child to participate in and attend as selected (all excursions/incursions will be advised of and a written consent form will be sought prior to attendance)
- I agree to discuss any concerns I have with the Programming with the Approved Provider/Nominated Supervisor
- I authorize staff to re/apply sunscreen to my child while attending the Service
  ☐Yes ☐I will provide sunscreen for my child
  ☐No
- I give permission for my child to be photographed for the purpose of curriculum planning, observations and portfolios, and display at the Service
  ☐Yes
  ☐No
- I give permission for my child to be photographed/filmed for the purpose of publicity and/or promotions for CHAMPS OSHC COLAC VIC
  ☐Yes
  ☐No
- I give permission for my child to participate in the following activities and experiences:
  ☐ Cooking activities (under adult supervision)
  ☐ Application and use of face paint
  ☐ Application and use of nail polish and other nail design products
  ☐ Application and use of hair styling products
- I consent to my child participating in the following celebrations:

☐Birthdays	☐Mothers Day	☐Fathers Day	☐ ANZAC Day
☐Christmas	☐Easter	☐New Year	☐ Australia Day
☐Lent	☐Ramadan	☐Halloween	☐ Chinese New Year

☐ Other ……

- My child has the following medical condition/s, and/or special needs that may effect their participation in specific Program activities *(please refer to enrolment)* :

☐Medication/s	☐Allergies	☐Anaphylaxis	☐ Asthma
☐Disability	☐Special Needs	☐Epilepsy	☐ Eczema

☐ Other ……

Child's Name_____

Parent/Guardian Name_____

Signature: _____**Date:**_____/_____/_____

Emergency Contact _____

Phone: _____ **Phone:** _____

Doctor: _____ **Clinic:** _____

Phone: _____ **Ambulance:** _____

Authority to Collect Child from Service

- Do not include Parent/Guardian names in this section
- All persons authorized to collect the child must be over 18 yrs of age
- Any person unknown to staff will be required to produce photo I.D

☐ I authorize the following person/s to collect this child from CHAMPS OSHC COLAC VIC Service.

Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**
Mobile:	**Mobile:**
Relationship to child:	**Relationship to child:**

Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**
Mobile:	**Mobile:**
Relationship to child:	**Relationship to child:**

Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**
Mobile:	**Mobile:**
Relationship to child:	**Relationship to child:**

Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**
Mobile:	**Mobile:**
Relationship to child:	**Relationship to child:**

Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**
Mobile:	**Mobile:**
Relationship to child:	**Relationship to child:**