SOUTHPORT STATE OUTSIDE SCHOOL HOURS CARE ENROLMENT

Coordinator: Danielle Edmond **Phone: 55 311138**
Email: soshc@bigpond.net.au **Mobile Phone: 0407 140 528**

CHILD DETAILS

	Class	Gender	Date of Birth
Name of **C**hild 1 _____	_____	Male/Female	___ /___ / ___
Child's CRN _____			
Child's Address _____			
Name of Child 2 _____	_____	Male/Female	___ /___ / ___
Child's Address _____			
Child's CRN _____			
Name of Child 3 _____	_____	Male/Female	___ /___ / ___
Child's Address _____			
Child's CRN _____			
Name of Child 4 _____	_____	Male/Female	___ /___ / ___
Child's Address _____			
Child's CRN _____			

MEDICAL RECORD

Child's doctor/ hospital _____ **Phone Number** _____
Medicare Number _____
Do any of your child/ren suffer from any medical incapacity, allergies or condition? Yes/No
(Please give details)_____
_____

Is your child anaphylactic? Yes/No if yes, please provide epi pen and management plan

If your child has asthma please describe their individual asthma triggers, types of medications used and administering of medication (e.g. self administering under supervision). Please provide an asthma management plan

Please give details of any medication your child uses: _____

_____

Do you authorise staff to give your child/ren medical attention? Yes / No
Is your child immunised? Details (please attach copies or provide original to staff) Yes/No

Immunisation record sighted by staff Yes/No

In the event of an emergency your child will be transported by ambulance to the nearest public hospital for treatment. Parents/Guardians will be notified as soon as possible.

OTHER DETAILS

Does your child require support for a disability/special needs? _____

_____

Does your child have any special dietary requirements? If so please specify_____

_____

Any cultural or religious requirements? If so please specify_____

_____

BOOKINGS: PLEASE INDICATE DAYS REQUIRED CASUAL ( ) PERMANENT ( )

Before School Care (please circle)	**M**	**T**	**W**	**TH**	**F**
Indicate Number of Children Attending	__	__	__	__	__
Start date: / /					
After School Care (please circle)	**M**	**T**	**W**	**TH**	**F**
Indicate Number of Children Attending	__	__	__	__	__

PARENT/GUARDIAN DETAILS

Parent date of birth & customer reference number must be provided for the parent who has claimed child care benefit.
*****PLEASE NOTIFY US IMMEDIATELY IF YOUR ADDRESS OR ANY CONTACT PHONE NUMBERS CHANGE*****

	Mother/Guardian	**Father/Guardian**
Name		
Address		
Parent Date of birth **(Compulsory for CCMS & child care Benefit fee reduction)**		
Customer Reference Number – CRN **(Compulsory for CCMS & child care Benefit fee reduction)**		
Home Phone Number		
Work Phone Number		
Mobile Phone Number		
Email address (to send monthly statements)		

Are there any parenting orders relating to your child: **Yes** **No** (please circle)
Has a copy of relevant documentation been provided **Yes** **No** (please circle)
(Relevant documentation may include Parenting Plans, Parental Responsibility Plans, Residence orders and Contact Order)

Emergency Contacts/Collection and Authorisation Details

In the event we cannot contact you in an emergency please provide details of two people we can contact regarding your child. They will also be authorised to give consent to medical treatment, administration of medication and in the case of an emergency, permission for transportation by Ambulance Service.

	Emergency Contact	**Emergency Contact**
Name		
Address		
Phone Number		
Mobile Phone Number		
Relationship to child.		
	Emergency Contact	**Emergency Contact**
Name		
Address		
Phone Number		
Mobile Phone Number		
Relationship to child.		

PLEASE NOTE WITHOUT PRIOR APPROVAL IN WRITING FROM PARENT / GUARDIAN WE CANNOT RELEASE A CHILD INTO THE CARE OF A PERSON NOT LISTED ABOVE.

I have read the above and given the correct information to the best of my knowledge. I agree that if any of these details change I will notify the Coordinator immediately. I understand that in the event of an emergency I give the staff at Southport State OSHC authorisation to give and seek medical attention. I have received a parent information booklet outlining the policy of the program and agree to abide by this policy. I am aware I can have access to a full copy of the service policies and procedures. I give consent to the service taking photos or video images of my child and used to promote their involvement in relevant programs and activities.

Parent Name: _____Parent Signature…….Date……

All enrolments and bookings are to go directly to Coordinator at OSHC.

PARENT INFORMATION SHEET

Southport State School Outside School Hour Care
215 Queen Street
Southport QLD 4215
Contact Details:
Co-ordinator - Danielle Edmond
Mobile - 0407 140 528
Phone - 55 311138
E-mail - soshc@bigpond.net.au

HOURS OF OPERATION

Before School - 6.45am to 9.00am **After School – 2.45pm to 6.00pm**

Vacation Care – 6.45am to 6.00pm **Pupil Free Day - 6.45am to 6.00pm**

Public Holidays – CLOSED **Christmas Holidays – to be advised, closed for one week**

LATE COLLECTION AND FEE PAYABLE

This services closes at 6.00pm. A Late Fee will apply after 6.00pm at $2.00 per minute for the first 10 minutes and $5 per minute thereafter. If you are going to be late a courtesy call is required by parents or alternatively after 6.15pm your child will be taken to Southport Police Station if no call is received.

FEE STRUCTURE

	Booked/Casual Rate	Cost per Session	Hours
Before School Care	**Booked Rate**	**$9.50 per session**	**6:45am to 9.00am**
	Casual Rate	**$11.00per session**	**6:45am to 9.00am**
After School Care	**Booked Rate**	**$16.50 per session**	**2:45pm to 6.00pm**
	Casual Rate	**$18.00 per session**	**2:45pm to 6.00pm**
Vacation Care	**Booked Rate**	**$42.00 per day**	**6.45am to 6:00pm**
	Casual Rate	**$47.00 per day**	**6.45am to 6.00pm**

FEE PAYMENT

Payment can be made by way of: **cash** **eftpos /credit** **cheque** **direct credit**

Account Name: Southport State School's P&C OSHC Grant Account

Bank: ***Commonwealth Bank***
BSB: ***06 4430***
A/c Number: ***10173557***
*******Please include your child's name as a reference******

VACATION CARE AND EXCURSIONS

Vacation care programs available for booking two weeks prior to each school holiday. Programs and booking forms are on display at sign in/out area. Your child will be unable to attend excursions unless a signed permission form is completed by Parent /Guardian.

Permission and Agreement Details

Child/ren Names:_____

(Please tick the appropriate boxes to signal your agreement)

☐ I give my consent to the information contained in this document being available to the Educators employed to work with my child on the Outside School Hours Care Program. I understand this information will be handled strictly in accordance with Privacy and Confidentiality Guidelines and will only be shared as a way of improving the quality of service provision to my child.

☐ I agree to notify the Coordinator, in writing, of any change in circumstances from the details as outlined in this enrolment form, including contact details and living arrangements of my child and/or parent/guardian.

☐ I agree to inform the Coordinator of any absence of my child as soon as possible and to pay any fee that may be incurred.

☐ I understand that the nature of the activities will include, but is not limited to, centre based activities/community outings/meal times and that risk may arise during these activities. I understand that I will receive a separate permission form for any excursions.

☐ I agree to pay for all fees (including excursion costs) of the days that my child attends the program. I understand that notice of non-attendance must be given and that I will be charged for the booked sessions.

☐ I authorise OSHC staff to provide any required first aid and to facilitate medical attention in the event of an emergency. I give permission for OSHC staff to obtain any medical and/or hospital information and to seek Ambulance Service transportation in the case of an accident or emergency involving my child. I accept responsibility for payment of all expenses associated with such treatment. I understand that every effort will be made to contact me in the event of any illness or accident.

☐ I give permission for my listed emergency contacts to give consent to medical treatment, authorise administration of medication and in the case of emergency authorisation for Ambulance Service transportation.

☐ I agree to keep my child from attending the program should he/she be experiencing any illness or contagious disease.

☐ I give permission for staff to take photos of my child to record important events and special activities as part of the program. I understand that these photos will be displayed for the families to see and will also be used for the purposes of programming and evaluation. I understand thatthese photos will be displayed only at the service and on the service Facebook page.

☐ I understand that should my child's behaviour be unable to be supported by staff, that I will be contacted and asked to collect my child.

☐ I agree to receive programs and account statements via email as listed below.

☐ I agree to adhere to the services Outside School Hours Care (OSHC) Policies and Procedures, as outlined in the OSHC Family Handbook.

PARENT/GUARDIAN:

NAME: _____ SIGNED: _____ DATE

*** Permission for Medical Treatment ***

To be presented to medical personnel in case
of emergency involving a child in day care.

My child(ren) _____ is (are) enrolled in the licensed Outside School Hours Care (OSHC) service at Southport State School.

By signing this form I give permission to qualified medical personnel to provide medical treatment to my child(ren) while in the care of Southport State School OSHC or their employees, but only in case I cannot be contacted to give permission personally, or I am otherwise unavailable.

Until I can be contacted or become available, please cooperate with Southport State School OSHC in providing medical care as they see fit.

Please provide care and treatment to minimize unnecessary pain, complications, scarring, or delays in recovery, as well as to protect life and limb.

Southport State School OSHC has liability insurance through the Marsh Pty Ltd Insurance.

Known allergies to antibiotics or medicines:
_____

I do not give permission for the following treatments: _____
_____
_____

My preferred physician, when available, is _____
My preferred clinic or treatment facility is _____
My medical insurance is _____

Special instructions and comments _____
_____

Phone numbers where I might be reached: Home: _____
Work: _____ Mob: _____
Other: _____

I _____hereby, give permission for OSHC staff to authorise transportation by Ambulance Service. I also give permission for my listed emergency contacts to give consent to medical treatment, authorise administration of medication and in the case of an emergency, authorisation for transportation by Ambulance Service.

_____	_____	_____
(Signature, parent or guardian)	(Printed name)	(Date)
_____	_____	_____
(Signature, parent or guardian)	(Printed name)	(Date

All accounts need a credit card form completed.

I _____give authority for Southport State School P&C OSHC to debit my credit card for fees owing weekly or fortnightly (please circle)

Card Type: Visa ☐ Mastercard ☐

Card Number

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry Date: _____ /_____

Name on Card: _____

Signature:_____
Date:_____

Important Note: Should you close your credit card account or your card expires, you must inform us and make new arrangements.

Direct Credit

Our Bank account details

Account Name: Southport State School P&C Assn OSHC

BSB number: 06 4430

Account number: 1017 3557 **(Please put your child's name as a reference)**

Please note: if you decide to do direct credit into our bank account, we will still require your credit card details on file in case payments are overlooked