

Snug Primary School
Outside School Hours Care
Enrolment Form
2020

Snug.Primary.OSHC@education.tas.gov.au

6267 9230

0419 881 165

CCS Service ID: 190008278V

ABN: 15 488 463 060





Child Details

Given Name(s): _____ Surname: _____
Preferred Name: _____ Gender: Male / Female
CRN: _____ Date of Birth: DD / MM / YYYY Country of Birth: _____
Address: _____
Suburb: _____ Postcode: _____
Languages spoken at home other than English: _____
Does your child identify as (please circle): **Aboriginal** and/or **Torres Strait Islander**

Please read carefully and tick/complete the sections relevant to your child:

- ☐ My child has a sibling attending another approved service on a regular basis.
Siblings name/s: _____
- ☐ My child is medically immunised and a copy of the Immunisation Record is attached.
- ☐ I have chosen not to have my child medically immunised and I am aware of the Service's Exclusion Policy and that this may impact CCS.
Where a child has not been medically immunised a Statutory Declaration must be provided before your child can attend SPSOSHC. Please refer to the Immunisation Policy for further details.
- ☐ There are Court/Parenting Orders in place in relation to my child, and a copy of the Orders is attached.
- ☐ I give permission for my child to participate in celebrations at SPSOSHC such as Christmas, Birthdays, Easter, etc. If not, please describe:

- ☐ Any special considerations for my child including cultural, religious, likes, dislikes, needs, strengths, dietary requirements, behaviour support or additional needs:

- ☐ Any special considerations (i.e. religious, medical) in case of an accident?

- ☐ Details of any dietary restrictions or requirements: _____



Medical Details

Please read carefully and tick/complete the sections relevant to your child:

My child has been diagnosed with the following medical conditions and/or health care needs:

- ☐ My child has been medically diagnosed with (Please circle as applicable):
Anaphylaxis/Asthma/Diabetes/Epilepsy/Other _____
- ☐ I understand that where my child has been diagnosed medical condition, they must not attend SPSOSHC without their current Medical Management Action Plan, Risk Minimisation Plan and prescribed medication.
- ☐ A copy of the Medical Management Action Plan, completed by our Doctor, is attached.
- ☐ My child is prescribed a regular medication and I will ensure a related Medical Authorisation Record is completed.
- ☐ Other relevant medical history:

Child's Doctor: _____

Phone: _____

Address: _____

Child's Dentist: _____

Phone: _____

Address: _____

Medicare Number: _____

Private Health Fund: _____



Parent Permissions

I **do / do not** give permission for my child to receive **medical, hospital** or **ambulance** treatment or care (including from Emergency Services).

I **do / do not** give permission for my child to be transported, if required, by an ambulance service.

I **do / do not** give permission for my child to have **photographs** taken and be displayed at the service.

I **do / do not** give permission for my child to have **photographs** taken for displays outside of the service (e.g. school newsletters, media, internet/Facebook, and advertising).

I **do / do not** give permission for my child to have **photographs** taken for Storypark (*Group stories/photos (2 or more children) will only be shared with the families of children tagged in the story. For more information around Storypark please contact us*).

I **do / do not** give permission for my child to **use the services sunscreen**. (Where your child does not use SPSOSHC sunscreen, you must provide your own).



Parent/Guardian Details

Parent/Guardian 1

Relationship to child: _____

Title: _____

First Name: _____

Surname: _____

D.O.B: _____

CRN: _____

Cultural Background: _____

Language Spoken: _____

Home address: _____

Suburb: _____

Post code: _____

Postal Address: _____

Home Phone no: _____

Mobile no: _____

Email Address: _____

Place of Employment:

Work address: _____

Suburb: _____

Phone: _____

Parent/Guardian 2

Relationship to child: _____

Title: _____

First Name: _____

Surname: _____

D.O.B: _____

CRN: _____

Cultural Background: _____

Language Spoken: _____

Home address: _____

Suburb: _____

Post code: _____

Postal Address: _____

Home Phone no: _____

Mobile no: _____

Email Address: _____

Place of Employment:

Work address: _____

Suburb: _____

Phone: _____

How would you like the accounts to be sent to you?

(Accounts are addressed and sent to **Parent/Guardian 1**)

☐ Emailed

☐ Posted



Authorised to Collect/Emergency Contacts

Please supply at least two contacts in case we are unable to contact Parent/Guardian 1 or 2.

Relationship to child: _____ Name: _____ Home address: _____ Suburb: _____ Home Phone: _____ Mobile: _____ Work Phone: _____	Authorised to (please tick): ☐ Collect your child/ren from the service ☐ Contact and collect if your child/ren are unwell ☐ Collect/contact in the case of an emergency (including a bushfire emergency) ☐ Consent to medical, hospital or ambulance treatment or care ☐ Sign any forms e.g. incident, excursion permission
Relationship to child: _____ Name: _____ Home address: _____ Suburb: _____ Home Phone: _____ Mobile: _____ Work Phone: _____	Authorised to (please tick): ☐ Collect your child/ren from the service ☐ Contact and collect if your child/ren are unwell ☐ Collect/contact in the case of an emergency (including a bushfire emergency) ☐ Consent to medical, hospital or ambulance treatment or care ☐ Sign any forms e.g. incident, excursion permission
Relationship to child: _____ Name: _____ Home address: _____ Suburb: _____ Home Phone: _____ Mobile: _____ Work Phone: _____	Authorised to (please tick): ☐ Collect your child/ren from the service ☐ Contact and collect if your child/ren are unwell ☐ Collect/contact in the case of an emergency (including a bushfire emergency) ☐ Consent to medical, hospital or ambulance treatment or care ☐ Sign any forms e.g. incident, excursion permission
Relationship to child: _____ Name: _____ Home address: _____ Suburb: _____ Home Phone: _____ Mobile: _____ Work Phone: _____	Authorised to (please tick): ☐ Collect your child/ren from the service ☐ Contact and collect if your child/ren are unwell ☐ Collect/contact in the case of an emergency (including a bushfire emergency) ☐ Consent to medical, hospital or ambulance treatment or care ☐ Sign any forms e.g. incident, excursion permission



Booking Form

Please complete all relevant sections and sign the completed Booking Form.

When requesting a casual booking, please email the service with dates and potential pickup/drop off times.

Requested booking times will be confirmed dependant on availability.

Before School Care:		
Commencement Date: ____/____/____		
7:00am-8:30am \$13	Permanent	Casual
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

After School Care:					
Commencement Date: ____/____/____					
	Permanent				Casual
	2:50-4:50pm \$16	2:50-5:50pm \$24	2:50-6:20 pm \$28	2:50-6:30pm \$32	
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					

I confirm:

- That my details in the enrolment form, as well as the details of the child I am enrolling are correct.
- I have agreed to days of care within the service(s) and understand the start and end times of these sessions of care.
- That care may be provided on a casual or flexible basis where available at my service(s) at my request and in line with the relevant policies and procedures.
- I understand I am liable to pay fees for the care of my child as indicated above and, if applicable, in other information the service has given me (such as a fee schedule or parent handbook) which are subject to change over time based on advice from the provider and acceptance by me.

Signature: _____

Date: ____/____/20____