Viewbank Primary School

Out of School Hours Care

Child Details and BookingForm

Co-ordinator: Pauline Pinner

Phone: 9459 7529 Service Approval: SE-00005497

In order to participate in the Viewbank Primary School Out of School Hours Care (OSHC) program, please complete this enrolment form and return it to OSHC. The OSHC program is unable to provide care for any child without the completion of this form prior to attendance. Each child enrolled in the program needs their *own* enrolment form.

CHILD BOOKING FORM	
Date of care to begin	
First Name	
Surname	
Date of Birth	
Country of Birth	
Gender	☐ Male ☐ Female
Street Address	
Suburb/City	
Postcode	
Child CRN	
Medicare No.	
Child's No. on Medicare Care	
Class/Grade	

BOOKING INFORMATION	
Before School Care	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday **OR** ☐ Casuals booking only
After School Care	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday **OR** ☐ Casual booking only
Are you claiming Child Care Rebate (CCR) as a fee reduction back to the service?	☐ Yes ☐ No Please contact Centrelink on 136 150 for further information on how to claim. *Please note, the VBPS OSHC will be unable to process this request without the correct CRN's for both the parent/guardian and the child/children.*

PARENT INFORMATION		
Email address for confirmation		
Name of Parent/Guardian #1		**Date of birth:** _____/_____/_____
Phone/Mobile No.		
Parent #1 CRN		
Name of Parent/Guardian #2		**Date of birth:** _____/_____/_____
Phone/Mobile No.		
Parent #2 CRN		

COURT ORDERS RELATING TO THE CHILD	
Are there any court orders relating to the powers, duties, responsibilities or authorities of any person in relation to the child or access to the child? **(please circle)**	☐ No - go to the next section ☐ Yes - please complete the following 1. Bring the original court order for the OSHC Nominated Supervisor to view and attach a copy of this to enrolment documents. 2. If these orders; change powers of a parent/guardian to; • Consent to medical treatment of the child • Request of permit the administration of medication to the child • Collect the child from the service AND OR • Give these powers to someone else Please describe these changes and provide the contact details of any person given these powers:

CHILD INFORMATION	
Family Doctor and/or Hospital	
Doctor's Address	
Doctor's Phone No.	
Medical conditions and details of specific health care needs of your child. Please attach additional pages if required.	
Medical Action Plan supplied	☐ Yes ☐ No
If answering YES to any of the following questions please note that you will be required to complete a Medical Management and Risk Minimisation form for any child with a medical condition before they can be accepted for care.	
Does your child have any allergies including being at risk of Anaphylaxis?	☐ No ☐ Yes - Please supply all Medical Management Plans and Risk Minimisation Plans including Asthma and Anaphylaxis Management Plans ***before commencing care***.
Does your child need staff to administer prescribed medication?	☐ No ☐ Yes - Please ask for and complete a Medication Form
Does your child have any fears?	☐ No ☐ Yes - Details_____
Has your child received the relevant immunisations for their age?	☐ Yes ☐ No - It is a requirement to provide a letter of exemption from your doctor
Does your child have any special dietary requirements?	☐ No ☐ Yes - Details _____
Does your child have any disability needs?	☐ No ☐ Yes - Details _____
Main language/s spoken	
Religion	
Are there any cultural issues that you would like our staff to be aware of, and respect, in dealing with you and your child?	☐ No ☐ Yes - Details:

EMERGENCY CONTACTS	
Please advise the name of persons authorised to collect your children other than parents/guardians. We require at least 2 other adults other than yourself that can collect your child/ren in the event we are unable to contact either parent/guardian. Children will only be released into the care of persons listed in writing and proof of identity will be required. We require accurate address and phone information in order to confirm identity.	
Contact #1	
Full name	
Relationship to child	
Address	
Mobile No.	
Authorities include	☐ Permission to collect ☐ Permission to contact in emergencies ☐ Permission to be able to consent to provide consent for the administration of medication ☐ Permission to be able to provide consent to medical treatment in the event that the parent/guardian is unable to be contacted ☐ Permission to be able to provide consent for an Educator of the Viewbank PS OSHC Service to take the child outside of the service in order to receive medical treatment.
Contact #2	
Full name	
Relationship to child	
Address	
Mobile No.	
Authorities include	☐ Permission to collect ☐ Permission to contact in emergencies ☐ Permission to be able to consent to provide consent for the administration of medication ☐ Permission to be able to provide consent to medical treatment in the event that the parent/guardian is unable to be contacted ☐ Permission to be able to provide consent for an Educator of the Viewbank PS OSHC Service to take the child outside of the service in order to receive medical treatment.

ACTION PLAN FOR ANAPHYLAXIS

My child _____ (insert childs name*) does not suffer* from a medically diagnosed Anaphylaxis.

OR

My child _____ (insert childs name) *does suffer* from a medically diagnosed Anaphylaxis and the ASCIA Action Plan for Anaphylaxis has been completed in full and attached.

I have supplied an adrenaline auto injector and this device is kept in the following location (ie. childs school bag):

I will replace this adrenaline auto injector before the expiry date. The expiry date is:___/___/___

I have consulted with my child's doctor and authorize the staff at Viewbank Primary School Out of School Hours Care to follow the ASCIA Action Plan for Anaphylaxis (attached). I will notify the OSHC program in writing if there are any changes to these instructions. I understand that I will be contacted if my child requires emergency treatment or if my child regularly has mild to moderate symptoms.

Parent name: _____

Parent signature: _____

ASTHMA DETAILS AND ACTION PLAN

I have consulted with my child's doctor and authorize the staff at Viewbank Primary School Out of School Hours Care to follow the Emergency Asthma Plan (attached) to assist my child in the event of asthma symptoms worsening. I will notify the OSHC program in writing if there are any changes to these instructions. Please contact me if my child requires emergency treatment or if my child regularly has asthma symptoms.

Parent name: _____

Parent signature: _____

BEHAVIOUR SUPPORT	
Are there any additional things you would like to tell us about your child that would help us support their behaviour in our programs?	☐ No ☐ Yes - Details _____

PERMISSIONS
In the event of an emergency, Illness or accident concerning my child and the Viewbank Primary School OSHC being unable to contact me or another person authorised by me, I consent to the Viewbank Primary School OSHC staff to seek on my behalf medical, dental, hospital and ambulance attention for my child and I accept liability for medical, dental, hospital and ambulance expenses where incurred. If the Doctor listed on the enrolment form or the nearest Doctor available considers immediate medication, anaesthetic or surgery he/she has my permission to administer whatever procedure is deemed necessary. In the event of a medical emergency, which is deemed life threatening, an ambulance will be contacted as the first priority by Viewbank Primary School OSHC staff prior to contacting parents. We recommend that all children attending our Service should have ambulance cover. I agree to the above conditions: Signed: _____ Name: _____ Date: __ / __ / ____

PHOTOGRAPHIC CONSENT **I give permission for my child's photo/video to be taken and I realise that the photo/video may be used on public display or used for the Viewbank Primary School OSHC program e.g. Newsletter**	☐ Yes ☐ No
SUNSCREEN CONSENT **I give permission for my child to have SPF 30+ sunscreen applied as per the SunSmart policy.**	☐ Yes ☐ No
CONSENT TO VIEW "PG" RATED MOVIES **I give permission for my child to view movies with a "PG" rating**	☐ Yes ☐ No

POLICY AND PHILOSOPHY STATEMENT **I agree to abide by all Policy and Philosophy guidelines of the VBPS OSHC Service as outlined in the Parent Handbook and Policy document.**	☐ Yes ☐ No

I accept full responsibility of my child's belongings whilst attending the program. I fully understand that if my child continuously does not follow; the behavioural expectations of the program, not listening to staff and respecting everyone and their safety whilst at the program, I will be notified and my child will be removed from the Viewbank Primary School OSHC program.

Parent/Guardian Signature:_____

Date:____/____/____

Office Use Only

Version	2
Date Printed	December 2015
Owner	Viewbank Primary School OSHC
Medical Management Package handed to parent	Date given to parent: / /
Review frequency	Annually
Next review date	June 2016