CCAS Vacation Care Enrolment Form

If you wish to receive the CCB (child care benefit) **you <u>must</u> be assessed by Family Assistance and provide the Centre <u>with the letter</u> they provide as well as the following information. If this is not supplied the *FULL* fee will be charged.**

Child's DOB:____/_____/_______ Child's CRN: _______________________

Primary Carer's DOB: _____/______/______ Primary Carer's CRN: ________________

Children attending another approved childcare service? **Yes / No** Total no. of children in care (for CCB rate)? _______

Insert Photo Here

Child's Details

Surname: ____________________________________

Given Names: ________________________________

Gender: Male/Female

Class: _____________

Date Commencing CCAS OSHC: ____/______/_______

Child's Cultural background/religion: ____

Is the child of Aboriginal or Torres Strait Islander descent? (Please specify)_________________

Family Details

1. Parent/Guardian **(CCB registered/statement billed to)**

Surname: _________________________ Given Name: ________________________________

DOB: _____/______/_______ Relationship to child: ________________________

Address: ____

Occupation: _______________________________ Employer: ___________________________

Home Phone: ______________________________ Work Phone: _________________________

Mobile: ____________________________________

Email: ____

2. Parent/Guardian

Surname: _________________________ Given Name: ________________________________

DOB: _____/______/_______ Relationship to child: ________________________

Address: ____

Occupation: _______________________________ Employer: ___________________________

Home Phone: ______________________________ Work Phone: _________________________

Mobile: ____________________________________

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Email:

____

If parents are separated, does the other parent have legal access to the child?

Yes / No Details: ____

Please Note: Court Orders must be sighted by the Director and a copy taken if you circle 'No'

Non Parent Emergency Contacts

You MUST provide the names of TWO authorised person/s to pick up child/ren other than Parent/Guardian. (Must be 18 years +) Contacts MUST be available to pick your child up during the hours of care and be within a reasonable distance from the Centre.

1. Name:__________________________________ Relationship to child: __________________________________

Hm:_________________ Work:_______________________ Mobile:_____________________________

Is this person authorised to sign in and/or out your children from care? ☐ YES ☐ No

2. Name:__________________________________ Relationship to child: __________________________________

Hm:_________________ Work:_______________________ Mobile:_____________________________

Is this person authorised to sign in and/or out your children from care? ☐ YES ☐ No

3. Name:__________________________________ Relationship to child: __________________________________

Hm:_________________ Work:_______________________ Mobile:_______________________________

Is this person authorised to sign in and/or out your children from care? ☐ YES ☐ No

Please list the names of **other people authorised to collect** your child/children (in addition to the above):

1. ______________________ 2. ______________________ 3. _____________________

Medical Authorisations

Please list any person who is authorised to consent to medical treatment for your child from a medical practitioner, hospital and/or ambulance service when a parent/guardian cannot be contacted:

1. Full Name:__________________________________ Relationship to child: __________________________________

Hm:_________________ Work:_______________________ Mobile:_____________________________

2. Full Name:__________________________________ Relationship to child: __________________________________

Hm:_________________ Work:_______________________ Mobile:_____________________________

Medical Details

Family Doctor: ______________________________ Medicare Number: ____________________

Address: _______________________________________ Phone Number: _______________________

Dentist: _______________________________________ Phone Number: _______________________

Health Fund Details: ____

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Immunisation

Has your child been fully immunised against: Hepatitis B, Hib, Pneumococcal, Measles, Mumps, Rubella, Chicken Pox, Tetanus, Diphtheria, Whooping Cough, Polio and Meningococcal C?

Yes / No **PLEASE NOTE,** if you have answered **NO**, list any diseases that your child has not been fully immunised against below. You are also required to provide a letter as a 'Conscientious Objector' otherwise you may not be eligible to receive the Child Care Rebate for your child.

____

____

Additional Needs and/or Medical Conditions

Does your child have any Additional Needs? *eg Autism, ADHD, ODD, Diabetes etc*

YES / NO If **YES** you must complete an "Enrolment Form B" and additional support forms eg KU Inclusion Support prior to acceptance of enrolment.

Does your child have any Allergies/ Intolerances? *eg Asthma, Anaphylaxis, Food Allergies etc*

YES / NO If **YES,** please provide details below: (eg. Doctor's /Specialists /Medical details)

____

____

Child Profile

Have you and your child completed the *Individual Child Profile* and attached it to the enrolment form?

☐ Yes ☐ No

This profile helps staff cater experiences around each individual child's likes and interest to create an enjoyable experience while at our Centre.

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Payment

For families whose child/ren do not attend Central Coast Adventist School Credit Card details must be supplied. Invoices will also be sent out to all families. Families who wish to make automatic credit card payments can also fill out the following information.

AUTOMATIC CREDIT CARD PAYMENTS

Family Name: ….…………………………..………… ………

Address: ……………………………………………………………………………………………….

Telephone Numbers: (Daytime)…………………………..… (Mobile)…………..…………………..

Pay by: Visa ☐ Bankcard ☐ Mastercard ☐ (Tick one)

Card Number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Amount: …………………

Expiry Date: _ _/_ _ Cardholder's Name: …………………………………………

Signature: ………..…………………………… Date: ……………………

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Permissions/ Authorisations

This section **must** be completed by the person who is CCB registered and the statements are billed to.

☐ I understand the staff at CCAS OSHC will seek medical attention and/or call an ambulance for my child in the event of an accident or emergency.

☐ **I give / ☐ I do not give** permission to the staff at CCAS OSHC to administer Panadol to my child if required, after contacting a parent/guardian. (**Tick whichever does apply)**

☐ **I give / ☐ I do not give** permission for my child to appear in photos in the Centre's newsletter or displayed in the room. (**Tick whichever does apply)**

☐ I understand that photos of my child will be taken for assessment and programming purposes.

☐ **I give / ☐ I do not give** permission for the parent/guardian identified at Number 2 of *Family Details* to request information about my child's account.

☐ **I give / ☐ I do not give** permission for the parent/guardian identified at Number 2 of *Family Details* to book my child into additional care days with the understanding that it will be billed to my account.

☐ **I give / ☐ I do not give** permission for my child to watch movies deemed appropriate by staff which have a rating of either 'G' or 'PG'.

☐ I have read and understood the **CCAS OSHC Parent Information Booklet & Code of Conduct**, and accept the conditions of enrolment.

____ _______/________/_________

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Signature of parent/guardian Date

INDIVIDUAL CHILD PROFILE

Name: ________________________________ Date: ____/______/_______

INTEREST AREAS

I like to play:

Things I like to do:

The food I like:

Things I don't like:

I'm afraid of (i.e. clowns, storms, dogs etc)

I like (i.e. cuddle when I'm sad, reminder to drink water etc)

Other comments: ____

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____

____

____

Created 10/2013

ENROLMENT FORM B
Additional Needs Information

The following questions are to help with the inclusion of children with additional needs at our Centre.

Child's Name: ______________________ Child's Age: ________________

Additional Needs for your child (please tick whichever is appropriate)

Physical: ☐ Cerebral Palsy ☐ Arthritis ☐ Other ______________________

Medical / Behavioural: ☐ ADHD ☐ ADD ☐ ODD ☐ Autism ☐ Epilepsy
☐ Visual Impairment ☐ Hearing Impairment
☐ Other ______________________

Please outline any professional agencies currently supporting or working with your child:

____

____

Describe any activities that your child should not do or will be restricted by because of health or medical reasons:

____

____

Does your child require additional support with daily routines and tasks eg eating, toileting? Please specify:

____

____

Please provide more information on your child's additional needs to assist our staff in enabling them to include your child in our daily program (eg behaviour strategies, interests, triggers):

____

____

Please describe how your child interacts with others (eg managing emotions, social situations, group settings):

____

____

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Please note that parents will need to review this form every time there is a change to your child's conditions.

Parent/Guardian Name:____

Signed: ____ Date: ________/_________/__________