CHILD'S NAME:

Office use only:
Date entered:_____By:
Enrolment Type: Form / Inform / AMEP / Other
CCB%: 1_____2___ 3_____4_____

ABCC ENROLMENT FORM
NEW CHILDREN

PLEASE COMPLETE A SEPARATE FORM FOR EACH CHILD, ATTENDING EITHER THE SPRINGFIELD ANGLICAN COLLEGE ABCC OR TSAC EARLY YEARS ABCC. ALL SECTIONS MUST BE COMPLETED.
ANY SECTION NOT COMPLETED WILL MEAN THE FORM IS RETURNED AND MAY CAUSE A DELAY IN YOUR CHILD'S COMMENCEMENT DATE AT ABCC.

PRIVACY:
The College adheres to the Australian Privacy Principles as set out in the Privacy Act (Cth) 1988. Further details are available in the College's Privacy Procedure located on the College's website.

1. CHILD DETAILS

CHILD'S FULL NAME:_____

HOME ADDRESS:_____

DOB:_____ ☐ MALE ☐ FEMALE CLASS:_____ COUNTRY OF BIRTH:_____

CHILD'S CENTRELINK REFERENCE NUMBER (CRN):_____ FAMILY CRN HOLDER: ☐ MOTHER ☐ FATHER
(FOR THIS CHILD)

ARE THERE ANY PARENTING ORDERS RELATING TO YOUR CHILD? ☐ NO ☐ YES

HAS A COPY OF THE RELEVANT DOCUMENTATION BEEN PROVIDED? ☐ NO ☐ YES

Relevant documentation may include Parenting Plans, Parental Responsibility Plans, Residence orders and Contact Orders

2. PARENT/GUARDIAN DETAILS

STATEMENTS: VIA EMAIL ☐

PARENT/ GUARDIAN 1 - ACCOUNT HOLDER

EMAIL ADDRESS: _____

NAME:_____ DOB:_____ COUNTRY OF BIRTH:_____

ADDRESS:_____ POST CODE:_____
(IF DIFFERENT TO CHILD)

PHONE: (H)_____ (WK.)_____ (MOBILE):_____

GENDER: ☐ MALE ☐ FEMALE RELATIONSHIP TO CHILD:_____ FAMILY CRN: _____

NUMBER OF CHILDREN IN CARE CLAIMING CCB%:_____(INCLUDING CHILD STATED ABOVE)

WORK STATUS: NOT APPLICABLE / WORK > THAN 15 HOURS A WEEK / LOOKING FOR WORK / STUDYING-TRAINING / DISABILITY- DISABILITY CARER
(CIRCLE APPLICABLE)
OCCUPATION:_____WORKPLACE SUBURB:_____

The date of birth and Centrelink reference numbers (CRN) for the account holder and each child are required for the purposes of linking for Child Care Benefits (CCB) and the 50% Child Care Rebate. Families MUST be assessed as eligible for Child Care Benefit, please contact the Department of Human Services on 13 61 50 for further information.

PARENT/ GUARDIAN 2 DUPLICATE STATEMENT REQUIRED: ☐ Email address: _____

NAME:_____ DOB:_____ COUNTRY OF BIRTH:_____

ADDRESS:_____ POST CODE:_____
(IF DIFFERENT TO CHILD)

PHONE: (H)_____ (WK)_____ (MBLE):_____

GENDER: ☐ MALE ☐ FEMALE RELATIONSHIP TO CHILD:_____ FAMILY CRN: _____

WORK STATUS: NOT APPLICABLE / WORK > THAN 15 HOURS A WEEK / LOOKING FOR WORK / STUDYING-TRAINING / DISABILITY- DISABILITY CARER
(CIRCLE APPLICABLE)
OCCUPATION:_____WORKPLACE SUBURB:_____

3. AUTHORISED NOMINEE/ EMERGENCY CONTACTS DETAILS

Please list the details of all persons, other than parents/guardians nominated in Section 2, who are authorized to collect your child and/or can be contacted in case of emergency. We require, at least, one emergency contact person whom is able to authorize emergency medical treatment or collect child.

Name:_____

Address:_____

Phone: (H)_____

(W)_____

(M)_____

Relationship to child:_____
Able to collect child: YES NO
Contacted in an emergency: YES NO

Name: _____

Address:_____

Phone: (H)_____

(W)_____

(M)_____

Relationship to child:_____
Able to collect child: YES NO
Contacted in an emergency: YES NO

Name:_____

Address:_____

Phone: (H)_____

(W)_____

(M)_____

Relationship to child:_____
Able to collect child: YES NO
Contacted in an emergency: YES NO

Name: _____

Address:_____

Phone: (H)_____

(W)_____

(M)_____

Relationship to child:_____
Able to collect child: YES NO
Contacted in an emergency: YES NO

4. HEALTH/MEDICAL DETAILS

Does your child have any medical conditions? ☐ NO ☐ YES

If yes, please provide details:_____

_____

Does your child require regular medication? ☐ NO ☐ YES

If staff will be required to administer medication, a separate medication authority form is to be completed by the parent/guardian. All medication is to be provided in the original packaging with the child's name and dosage.

Does your child have any allergies? ☐ NO ☐ YES (If yes, please provide details below)

_____ ☐ MILD ☐ SEVERE ☐ ANAPHYLAXIS

Please provide an allergy management plans relating to your child

Does your child experience asthma? ☐ NO ☐ YES (If yes, indicate severity) ☐ MILD ☐ SEVERE

Please provide details of any asthma management plans relating to your child

Is your child's immunization status up to date? ☐ NO ☐ YES DATE OF LAST TETANUS INJECTION:_____

CHILD'S HEALTH RECORD SIGHTED ☐ NO ☐ YES

13vPCV –Pneumococcal conjugate	☐ No	☐ Yes	Hep A -Hepatitis A	☐ No	☐ Yes
23PPV- Pneumococcal polysaccharide	☐ No	☐ Yes	Hep B -Hepatitis B	☐ No	☐ Yes
DTPa -Diphtheria, tetanus and pertussis	☐ No	☐ Yes	Rotavirus	☐ No	☐ Yes
Hib – Haemophilus Influenzae Type B	☐ No	☐ Yes	VZV – Chickenpox	☐ No	☐ Yes
MMR-Measles/Mumps/Rubella	☐ No	☐ Yes	Whooping Cough	☐ No	☐ Yes
Men CCV -Meningococcal C	☐ No	☐ Yes	OPV/IPV Inactivated Poliomyelitis	☐ No	☐ Yes

If your child's immunization status is not up to date, your eligibility to receive Child Care Benefit may be affected

Does your child have any specific dietary requirements? ☐ NO ☐ YES _____

_____

Does your child have any food intolerances? ☐ NO ☐ YES _____

_____

If yes, is the intolerance/allergy life threatening? ☐ NO ☐ YES

Please provide details of any food intolerance/allergy management plans relating to your child. If you have answered yes to any question in section 4 (excluding immunization information), please complete section 9 of enrolment form only on receipt of documents from ABCC staff.

5. MEDICAL PRACTITIONER DETAILS (MINIMUM ONE REQUIRED)

Doctor 1 Name:_____ Surgery/Practice Name:_____

Address:_____ Phone number:_____

Doctor 2 Name:_____ Surgery/Practice Name:_____

Address:_____ Phone number:_____

Family Medicare No: _____

6. ADDITIONAL INFORMATION

Does your child have any religious/cultural needs? ☐ NO ☐ YES _____

_____

Does your child have any dislikes, fears or phobias? ☐ NO ☐ YES _____

_____

Is your child of Aboriginal or Torres Strait Islander descent? ☐ NO ☐ YES

Is your child from a non-English speaking background? ☐ NO ☐ YES NATIONALITY: _____

Would you like information from Government regulators or additional ABCC information? ☐ NO ☐ YES

If possible, do you require a language other than English? ☐ NO ☐ YES Language:_____

7. BOOKING REQUIREMENTS

TSAC parents to complete Week 1 only. The Tiny Tartan Kindergarten parents to complete Weeks 1 & 2, as required.

Permanent days:
Before School Care: ***please indicate***

Week 1	Start Date:_____	☐ MON	☐ TUES	☐ WED	☐ THURS	☐ FRI
Week 2	Start Date:_____	☐ MON	☐ TUES	☐ WED	☐ THURS	☐ FRI

After School Care: ***please indicate***

Week 1	Start Date:_____	☐ MON	☐ TUES	☐ WED	☐ THURS	☐ FRI
Week 2	Start Date:_____	☐ MON	☐ TUES	☐ WED	☐ THURS	☐ FRI

Casual Care: ☐

Vacation Care programs and booking forms are available at least 2 weeks before the vacation care period starts. The program has a mix of in-house activities and excursion days.

Bookings are essential by returning the booking form sent out with the vacation care programs. Cancellations for booked days must have 48 hours' notice or the fee for that session will be charged.

8. PERMISSION & AGREEMENT DETAILS

This pertains to your child's continued attendance at ABCC so take the time to read before you continue.

(Please tick the appropriate boxes and initial beside each 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 Nominated Supervisor, 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 understand that it is my responsibility to ensure all Child Care Benefit requirements are fulfilled, in particular, ensuring eligibility for CCB, providing my/our date of birth and providing family and child Customer Reference Numbers.

☐ I agree to inform the Nominated Supervisor of any absence of my child as soon as possible and to pay any fee that may be incurred as a result of not cancelling within the specified timeframes, as set out in the service policy.

☐ 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 48 hours notice of non-attendance must be given otherwise I will be liable for, and charged, for the booked sessions.

☐ I authorize OSHC staff to provide any required first aid and to facilitate medical attention in the event of an emergency, including the administration of life saving medication (eg Epipen or Ventolin). I give permission for OSHC staff to obtain any medical, hospital and ambulance service in the case of an accident or emergency involving my child and 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 authorize OSHC staff to liaise with other health/medical professionals in relation to the care of my child.

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

☐ I give permission for OSHC staff to assist my child to apply a SPF 30+ sunscreen prior to outdoor activities. In case of allergy, I will provide my own SPF 30+ sunscreen.

☐ 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 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 promotional material, programs, newsletters and/or 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 1:

NAME:_____ SIGNED:_____ DATE: _____

9. MEDICAL CONDITION ADENDUM

THIS SECTION NEEDS TO BE SIGNED ON RECEIPT OF POLICIES 2.1, 2.2 & 2.3 AND IN THE PRESENCE OF A COLLEGE STAFF MEMBER.

If this enrolment form contains any YES answers in Section 4 – Health & Medical details then the Nominated Supervisor must ensure families receive the following information and that parent/guardians have read and understood the following information by signing and dating:

NAME:_____ SIGNED:_____ DATE: _____

☐ I have received a copy of the following ABCC Policies and Procedure documents

2.2 Medical Conditions Policy
2.3 Administering Medication Policy
2.4 Anaphylaxis and Other Medical Issues Management Plan

WITNESS
NAME:_____ SIGNED:_____ DATE: _____

10. KINDERGARTEN EXURSION FORM

During Term time and Vacation Care The Tiny Tartan Kindergarten ABCC may program activities outside the Kindergarten area but still within the precinct of Primary Campus.

The areas which could be visited include:

Prep & Lover Playgrounds	**Oval**	**Tennis Courts**	**Dance/Music Rooms**
Under covered Area & Courtyard	**Primary ABCC rooms & outside area**	**Library**	

I, _____, the parent/guardian of _____ give permission for my child to participate in activities to be programmed outside The Tiny Tartan Kindergarten area but inside The Springfield Anglican College Primary Campus precinct during Term time and the Vacation Care periods.

NAME:_____ SIGNED:_____ DATE: _____