

## Outside School Hours Care Centre Enrolment Form 2020

Ph: 6216 7900 Email: [info@mountcarmel.tas.edu.au](mailto:info@mountcarmel.tas.edu.au)

Postal Address: PO Box 217 SANDY BAY TAS 7006

Students currently enrolled in Outside School Hours Care to complete Page 4 only or if details have changed, please complete where applicable.

### Student information:

Full Name: \_\_\_\_\_

Residential Address: \_\_\_\_\_

\_\_\_\_\_ Post Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Child's CRN \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_\_ Country of Birth: \_\_\_\_\_ Sex: M / F

Is the student of Aboriginal or Torres Strait Islander origin:

- ☐ No
- ☐ Yes, Aboriginal
- ☐ Yes, Torres Strait Islander
- ☐ Yes, Aboriginal and Torres Strait Islander

### Custody/Parent/Carer information:

Name(s) of person(s) with legal guardianship of the student.

*Please detail any Court Orders, Parenting Orders or Parenting Plans and attach copies*

\_\_\_\_\_  
\_\_\_\_\_

Full Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Relationship to child (e.g. Mother/Father) \_\_\_\_\_

Residential Address: \_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_

Postal Address: \_\_\_\_\_ Postcode: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Business Phone No: \_\_\_\_\_  
Business Address: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

Full Name: \_\_\_\_\_  
Date of birth: \_\_\_\_\_  
Relationship to child (e.g. Mother/Father) \_\_\_\_\_  
Residential Address: \_\_\_\_\_  
\_\_\_\_\_ Postcode: \_\_\_\_\_  
Postal Address: \_\_\_\_\_ Postcode: \_\_\_\_\_  
Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Business Phone No: \_\_\_\_\_  
Business Address: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

**Parent Customer Reference No. (CRN): ( Mother / Father ) please circle**

**PARENT CRN:** \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_ **Date of Birth:** \_\_\_\_\_ (required by DHHS)

**NB: CRNs MUST be supplied, even if you are NOT claiming Childcare Subsidy.**

**Family details:**

Other language(s) spoken at home: \_\_\_\_\_

Number of children in family: \_\_\_\_\_ Position of this child in family (e.g. 1<sup>st</sup>) \_\_\_\_\_

Do you have other children in regular care at another facility? If so, how many: \_\_\_\_\_  
(This will be recorded for your CCS percentages)

**Emergency Contact (other than parents):**

***This person is deemed to have authority to consent to medical treatment for your child/ren.***

Name(s): \_\_\_\_\_

Relationship to student (e.g. aunt): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Address: \_\_\_\_\_

**Correspondence/Accounts to be sent to:**

Name(s) and addresses: *(please note, to comply with privacy conditions it is important that all parties are listed).*

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Does your child have any special needs we should be aware of, i.e. Culture or Religion?

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**Medical information**

Medicare No: \_\_\_\_\_ Health Cover: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone No: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone No: \_\_\_\_\_

Known Allergies & Special Dietary Requirements: \_\_\_\_\_

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Action to be taken if a related incident occurs? \_\_\_\_\_

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Any relevant medical problems (e.g. asthma, epilepsy, anaphylaxis, etc.)?

*(Please attach your child's Medical Plan)*

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Action to be taken if a related incident occurs? \_\_\_\_\_

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Immunisation records provided to the College: (Please circle)

YES / NO

**If your child is attending Long Day Care, Immunisation Records must be attached.**

*Mount Carmel College is a privacy compliant organisation. Your personal information will be used only for the purpose for which you provided it, and we will not disclose it without your consent, except where authorised or required by law.*

Student Name: \_\_\_\_\_

**Please tick days and times you require permanent care:**

Type of Care	Monday	Tuesday	Wednesday	Thursday	Friday
Before School Care	7.30am-9.00am <input type="checkbox"/>	7.30am-9.00am <input type="checkbox"/>	7.30am-9.00am <input type="checkbox"/>	7.30am-9.00am <input type="checkbox"/>	7.30am-9.00am <input type="checkbox"/>
After School Care	3.00pm-6.00pm <input type="checkbox"/>	3.00pm-6.00pm <input type="checkbox"/>	3.00pm-6.00pm <input type="checkbox"/>	3.00pm-6.00pm <input type="checkbox"/>	3.00pm-6.00pm <input type="checkbox"/>
Long Day Care	7.30am-6.00pm <input type="checkbox"/>	7.30am-6.00pm <input type="checkbox"/>			

Casual care only required - please tick

☐

Date Childcare to commence: \_\_\_\_\_

**Please note: Permanent bookings will be assumed for the entire school year. Any changes to your childcare requirements should be advised to the office ASAP. All permanent bookings will be charged for, regardless of whether the child is absent, or a booking is cancelled, except during Vacation Care & Public Holidays.**

### Excursion Consent Information

I (Parent/Carer Name) \_\_\_\_\_ parent/carer/legal guardian (delete as appropriate) of: (Student/s Name): \_\_\_\_\_ hereby

- Consent to my child travelling on any form of public or private transport where such transport is deemed by the school to be necessary or desirable.
- Consent to my child participating in all activities organised or available at school, and all other outings, excursions and functions.
  - In the event that you cannot be contacted: Consent to the school, by its servants or agents, seeking such medical or dental advice on behalf of my child as it sees fit in the event of accident or illness and, if in the opinion of an attending medical or dental practitioner or medical officer, my child requires medical or dental attention or treatment including but not limited to the administration of anaesthetic, blood transfusion or the performance of any surgical operation, to such medical or dental practitioner or medical officer giving such attention or treatment.
  - Certify that the consent which I have given in paragraph (a) is valid at all times while my child is in the custody of the school including but not limited to such items as my child is at school, is present at school camps or is attending or participating in excursions or functions.
- Certify that I understand that the centre will take all reasonable care in the event of my child suffering accident or illness but that it will not be responsible for the costs of any medical or dental attention or treatment administered to my child in such event nor will it be responsible directly or indirectly for any act or omission of any medical or dental practitioner or medical officer attending or treating my child.
- Tick appropriate box and give details where applicable:
  - I/We certify that my child does not, to my knowledge, suffer from any illness or disability which might interfere with or inhibit any medical or dental attention or treatment. ☐
  - I/We give notice that my child suffers from the following illnesses or disabilities and/or takes medication which might interfere with or inhibit any medical or dental attention or treatment, but certify that, to my knowledge, my child does not suffer from any **other** illness or disabilities or take medication which might interfere with or inhibit any medical or dental attention or treatment. ☐

Date: \_\_\_\_\_ Signed: \_\_\_\_\_



**Mount  
Carmel  
College**

We nurture.  
We challenge.  
We care.

## OUTSIDE SCHOOL HOURS CARE CENTRE

### Authority to Collect Form

I/We \_\_\_\_\_  
*Name of parent(s)/carer*

may not be able to collect our child(ren) personally from outside school hours care/ long day care.

In this event, I/we authorise and nominate the following persons to collect:

\_\_\_\_\_

\_\_\_\_\_  
*Name of child(ren)*

I understand that the nominees must be over the age of 18.

Name	Address	Relationship To Child	Contact Number	Signature of authorised person to collect

Date: \_\_\_\_\_ Signature of parent/carers(s) \_\_\_\_\_