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Outside School Hours Care Centre

Enrolment Form 2023

Ph: 6216 7900 Email: 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: _____

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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: _____
Home 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)
CRNs must be supplied, even if you are NOT claiming the Childcare Subsidy.

Family details:

Other language(s) spoken at home: _____
Number of children in family: _____ Position of this child in family (e.g. 1st) _____
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:_____

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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).

_____

_____

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

_____

Medical information

Medicare No:_____ Health Cover: _____

Family Doctor: _____ Phone No: _____

Doctor's Address: _____

Dentist: _____ Phone No: _____

Known Allergies & Special Dietary Requirements: _____

_____

_____

Action to be taken if a related incident occurs? _____

_____

_____

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

(Please attach your child's Medical Plan)

_____

_____

Action to be taken if a related incident occurs? _____

_____

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.

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Student Name: _____

Please tick days and times you require permanent care:

Type of Care	Monday	Tuesday	Wednesday	Thursday	Friday
Before School Care 7.30am – 8.30am	☐	☐	☐	☐	☐
After School Care 3.05pm – 6.00pm	☐	☐	☐	☐	☐

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:

1. 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.
2. Consent to my child participating in all activities organised or available at school, and all other outings, excursions and functions.
    a) 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.
    b) 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.

3. 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.

4. 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: _____

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Authority to Collect Form 2023

I/We (Name of parent(s)/carer) _____

may not be able to collect our child(ren) personally from outside school hours care. In this event, I/We authorise and nominate the following person(s) to collect and I/We understand that the nominees must be over the age of 18 years.

Name of child(ren):

_____

_____

_____

Name	Address	Relationship to Child(ren)	Contact Number	Signature of authorised person to collect

Signature of parent/carer(s) _____

Date: _____