



e. dl.0251.oshc@schools.sa.edu.au
a. Caffrey Street, McLaren Vale SA 5171

8323 9217

2024 OSHC Enrolment Form

Children's Information

Family Name: First Name: Gender: M/F
Date of Birth: ___/___/___ CRN: Aboriginal: Yes/No TS Island: Yes/No
Cultural Background: Language spoken at home:

Family Name: First Name: Gender: M/F
Date of Birth: ___/___/___ CRN: Aboriginal: Yes/No TS Island: Yes/No
Cultural Background: Language spoken at home:

Family Name: First Name: Gender: M/F
Date of Birth: ___/___/___ CRN: Aboriginal: Yes/No TS Island: Yes/No
Cultural Background: Language spoken at home:

Enrolling Parent/Guardian & Billing Details

Name: Date of Birth: ___/___/___
CRN: Relationship to Child:
Address: Suburb: Postcode:
Phone: (H) (W) (M)
Email address:
Cultural Background: Language spoken at home:
Occupation:

Other Parent/Guardian details (if applicable)

Name: Date of Birth: ___/___/___
CRN: Relationship to Child:
Address: Suburb: Postcode:
Phone: (H) (W) (M)
Email address:
Cultural Background: Language spoken at home:
Occupation:
Emergency Contact: Yes/No (Please circle) Collection Authority: Yes/No (Please circle)

Parenting Plans/ Orders relating to this child/ren

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.....
.....





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We require you to nominate at least two other people as emergency contacts. **(They must be over 18 years of age)** Please fill their details in the provided boxes below. In nominating them you give them the authority to act on the child's behalf if neither parent can be contacted and to pick up and care for them until he/she can be returned home.

It is essential that you tell these people that you have nominated them and inform us of any changes to their details. Only people listed on this form have the authority to collect children, unless the parent notifies the service otherwise.

Emergency Contact 3

Name: Miss/Ms/Mrs/Mr (given name) (surname)

Relationship to Child:

Phone: (H) (W) (M)

Collection Authority: Yes/No (Please circle)

Emergency Contact 4

Name: Miss/Ms/Mrs/Mr (given name) (surname)

Relationship to Child:

Phone: (H) (W) (M)

Collection Authority: Yes/No (Please circle)

Emergency Contact 5

Name: Miss/Ms/Mrs/Mr (given name) (surname)

Relationship to Child:

Phone: (H) (W) (M)

Collection Authority: Yes/No (Please circle)

Children in Care Elsewhere

I am claiming childcare benefit at other approved childcare services (which includes LDC, FDC, IHC, OCC) for this number of children:





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Medical Information

Has the child/ren received all immunisations appropriate for his/her age? Yes/No

If no, please give details

I accept full responsibility if my child/ren is not immunised

Parent/Guardian Signature:

Allergies: Yes/No (please circle)

Please list allergies:

Medical Needs/Disabilities/Additional Needs: (e.g. Asthma, ADHD, Autism)

Please outline:

Has the child/ren any special dietary needs not related to allergies? Yes/No

If yes, please give details.

Is there any other medical information we might need to know?

Medical Practitioner: Phone:

Medical Benefits cover with: Medicare No:

Ambulance Cover: Yes/No (Please circle)

DIAGNOSED HEALTH CARE NEEDS National Regulation (90) – CHILDREN CANNOT ATTEND OUR SERVICE until we have received the following:

1. Up-to-date Medical Management Plan (e.g. Asthma, Anaphylaxis, Allergic Reactions) This MUST have the plan date and review date.
2. Medical Conditions Risk Minimisation Plan and Communication Plan
3. Prescribed medication **National Regulation (95) Note: All medication must be in their original containers bearing the original label with the name of the child to whom the medication is to be administered**



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RISK MININISATION PLAN - Strategies to Avoid Triggers (Prepared by Parents and Service)

- Anaphylaxis, asthma and first aid trained educators are on the premises at all times.
- The medical management plan, risk minimisation plan and medication are accessible to all educators. Discussions to explain where these items are kept are held with parents, educators and volunteers.
- The child’s and service medication is stored in the prescribed location for the room and service.
- The child’s medication will be checked to ensure it is current and has not expired.
- There is a notification of child at risk of anaphylaxis displayed in the front foyer with other prescribed information.
- The Nominated Supervisor will identify all children with specific health care needs, allergies or diagnosed medical conditions to all new educators, staff, volunteers and students, and ensure they know the location of the child’s medical management plan, risk minimisation plan and medication.
 - Parents are required to authorise administration of medication on medication record, and educators will complete administration of medication record whenever medication is provided.
- A copy of parent’s authorisation to administer medication is attached to medical management plan and original filed in child’s file.
- The Nominated Supervisor will discuss with the parents about any allergens that pose a risk to the child.
- The service will display the child’s picture, first name, medication held and location, and brief description of medical condition on a poster in OSHC staff office and prominent places to alert all staff, volunteers and students.

Child Name:	Date of Birth: / /
Specific health care needs or diagnosed medical condition:	
Predominant Trigger/s (for example: eating certain food) PLEASE LIST TRIGGERS THAT RELATE TO CHILD:	
Other Allergy Triggers:	





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Office Use Only

What educators, staff and volunteers will do to minimize effect of triggers:
 (For example: services will be cleaned daily to reduce allergens; Service will use damp cloths to dust, so it is not spread into the atmosphere. Children will not have access to any foods that cause allergic reactions. Children will have access to foods that are appropriate for their dietary needs etc.)
 PLEASE NOTE THE RELEVANT RISKS, STRATEGIES AND WHO IS RESPONSIBLE IN THE TABLE BELOW.

<u>Risks</u>	<u>Strategy</u>	<u>Who is responsible?</u>





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MEDICAL COMMUNICATION PLAN (Prepared by Parents and Service)

Child Name:	Date of Birth: / /
Specific health care needs or diagnosed medical condition:	

The following communication plan is prepared in accordance with regulation 90(1)(iii) to set out how: relevant staff members, parents and volunteers are informed about the medical conditions policy; and, the medical management and risk minimisation plans for the child; and a parent of the child can communicate any changes to the medical management plan and risk minimisation plan for the child.

Service

Educators:

- will complete an Incident, Injury, Trauma and Illness form and advise you when your child requires medication where this has not previously been authorised (for a specific day or time);
- may enquire about the child’s health to check if there have been any changes in their condition or treatment;
- acknowledge that a copy of the Medical Conditions Policy has been provided and is available in the service.

The Nominated Supervisor will:

- advise all new educators, staff and volunteers about the location of the child’s medical management plan, risk minimisation plan and medication as part of their induction;
- review the child’s medical management plan, risk minimisation plan and medication regularly at staff meetings, and seek feedback from educators about any issues or concerns they may have in relation to the child’s medical condition;
- regularly remind parents of children with health care needs, allergies or diagnosed medical conditions to update their child’s medical management plan, risk minimisation information and medication information through newsletters and information on parent noticeboards; and
- update a child’s enrolment and medical information as soon as possible after parents update the information.

Parents

Parents will:

- advise the Nominated Supervisor and educators of changes in the medical management plan or medication as soon as possible after the change, and immediately provide an updated medical management plan, medication and medication authorisation (if relevant);
- provide an updated medical management plan annually, whenever it is updated or prior to expiry;
- provide details annually in enrolment documentation of any medical condition;
- advise educators in writing on arrival of symptoms requiring administration of medication in the past 48 hours and the cause of the symptoms (if known); and
- acknowledge a copy of the Medical Conditions Policy has been provided and is available in the service.

Other comments:

I/we agree to these arrangements, including the display of our child’s picture, first name, medication held and location, and brief description of allergy/condition on a poster in staff office to alert all staff, volunteers and students. Also, the above information on forms is correct and current.

Signed: _____ Date: _____

Parent/Guardian

Name of Parent/Guardian

<p>Office Use Only</p> <p>Enrolment form pages have been reviewed and completed. Nominated Supervisors:</p> <p>Signature: _____</p> <p>Date: _____</p>



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Consents:

I consent for my child to take part in supervised walking excursions within the local area as part of the centre's program

Yes/No Signed:

I consent for my child watching G and PG movies at OSHC

Yes/No Signed:

I consent to photo, video, and audio of my child being recorded as part of programmed activity for purposes such as documenting learning, sharing podcasts/videos and displays at the service and online through our website and the SkoolBag app

Yes/No Signed:

I consent to my child's photos to be displayed on our OSHC Facebook page

Yes/No Signed:

Agreements:

I agree to pay the required fees for my child's booked OSHC hours and accept the policies and rules of the service.

I am familiar with the Account Terms and Conditions and understand that accounts must be paid within seven (7) days from the date of notice.

I agree to provide an updated medical action plan and required medication to OSHC if my child has any medical conditions/allergies.

I agree that the staff of the service may administer simple first aid to my child if it arises.

I understand that if at any time the staff of the service consider my child requires emergency medical assistance, they will have the ambulance attend my child. I acknowledge that I will be liable for any expenses incurred in the treatment of my child.

I certify that the information entered upon this form is true to the best of my knowledge and I undertake to inform the service if any of these details change.

Parent/Guardian signature: Date ___/___/___





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Complying Written Arrangement for Child Care Subsidy - 2024

Dear families, please confirm acceptance of the following items so that our Service can receive Child Care funding on your behalf and reduce your fees

Parties to the Agreement

Between	Name: _____ Address: _____
And	McLaren Vale Primary School OSHC, ABN 92 894 579 963
For the Care of	Child's Name: _____ DOB: _____ Start Date: _____ Child's Name: _____ DOB: _____ Start Date: _____ Child's Name: _____ DOB: _____ Start Date: _____
By	McLaren Vale Primary School OSHC, Caffrey Street Phone: 8323 9217 Email: dl.0251.oshc@schools.sa.edu.au

Routine/ongoing care Before School Care (please tick)

Day	Care Required	Session start	Session end	Fee	Unit
Monday		6:45 am	8:30 am	14.00	Session
Tuesday		6:45 am	8:30 am	14.00	Session
Wednesday		6:45 am	8:30 am	14.00	Session
Thursday		6:45am	8:30 am	14.00	Session
Friday		6:45 am	8:30 am	14.00	Session

Routine/ongoing care After School Care (please tick)

Day	Care Required	Session start	Session end	Fee	Unit
Monday		3:05 pm	6:30 pm	24.00	Session
Tuesday		3:05 pm	6:30 pm	24.00	Session
Wednesday		3:05 pm	6:30 pm	24.00	Session
Thursday		3:05 pm	6:30 pm	24.00	Session
Friday		3:05 pm	6:30 pm	24.00	Session

Casual/flexible care

Day	Fee	Unit
Any	\$29.00	Session

Vacation Care

Day	Fee	Unit
Any	\$55.00	Session

I confirm:

- the details I have provided above are true and correct
- I have agreed to the days of care and the start and end times of these sessions
- care may be provided on a casual or flexible basis where available at the Service in addition to routine care and
- I am liable to pay fees for my child's care as indicated above and in line with other information the Service makes available to me (such as a Fee Schedule) which are subject to change over time based on advice from the Provider.

Parent/Guardian Signature _____

Date / /

