



Montmorency Primary School

Out of School hours Care

60A Rattray Road, Montmorency 3094 Telephone: 9434 5944

Enrolment Form

The following information is confidential and will only be used by Staff for the purpose of looking after the children.

1. First Name _____ Family Name _____

What would you like us to call the child? _____

Gender F M Date of Birth ____ / ____ / ____

Grade _____ Teacher _____

Centrelink Customer Reference Number (CRN) _____

Allergies: _____

Medical allergies: _____

Medical conditions: _____

Asthma Y (please attach management plan) N

2. First Name _____ Family Name _____

What would you like us to call the child? _____

Gender F M Date of Birth ____ / ____ / ____

Grade _____ Teacher _____

Centrelink Customer Reference Number (CRN) _____

Allergies: _____

Medical allergies: _____

Medical conditions: _____

Asthma Y (please attach management plan) N

3. First Name _____ Family Name _____

What would you like us to call the child? _____

Gender F M Date of Birth ____ / ____ / ____

Grade _____ Teacher _____

Centrelink Customer Reference Number (CRN) _____

Allergies: _____

Medical allergies: _____

Medical conditions: _____

Asthma Y (please attach management plan) N

BOOKING DAYS

Type of Care	Monday	Tuesday	Wednesday	Thursday	Friday
Before Care					
After Care					

If there are changes please notify Donna, the Coordinator, ASAP.

PARENT / GUARDIAN DETAILS

Child resides with: (please circle) Both parents Guardian
Mother S M T W T F S Father S M T W T F S
Are there special access/ custody arrangements Yes No
If yes, please give details. If a court order exists please provide this information to the Coordinator.

Parent/ Guardian 1 must be main contact with Centrelink for CCB/ CCR purposes and the account will be emailed to this person. **THIS MUST BE COMPLETED.**

Parent/ Guardian 1
First Name: _____ Family name: _____
Address: _____
Occupation: _____
Phone H: _____ W: _____ :M _____
Email address: _____
Date of Birth: ____ / ____ / ____
Centrelink Customer Reference Number (CRN): _____
Relationship to child: _____

Parent/ Guardian 2
First Name: _____ Family name: _____
Address: _____
Occupation: _____
Phone H: _____ W: _____ :M _____
Email address: _____
Date of Birth: ____ / ____ / ____
Centrelink Customer Reference Number (CRN): _____
Relationship to child: _____

EMERGENCY CONTACT DETAILS AND PEOPLE AUTHORISED TO COLLECT YOUR CHILD OTHER THAN YOU.

These people need to be located at a maximum of 30min by car distance away from the service at MPS and able to collect the child if you are delayed. At least 2, preferably 3 people, are needed as contacts in case we cannot get a hold of you in the case of an emergency.

Family Name: _____ First Name: _____
Relationship to Child: _____
Address: _____
Phone H: _____ W: _____ M: _____

Family Name: _____ First Name: _____
Relationship to Child: _____

Address: _____
Phone H: _____ W: _____ M: _____

Family Name: _____ First Name: _____
Relationship to Child: _____
Address: _____
Phone H: _____ W: _____ M: _____

MEDICAL INFORMATION

Please provide details and management plans of any medical conditions mentioned.

DOCTORS INFORMATION

Children's Doctor Name: _____
Address: _____
Phone: _____ Medicare No: _____
Do you subscribe to an Ambulance service? Y N
Details: _____

FOOD REQUIREMENTS

Is your child vegetarian? Yes No

Is there any food your child(ren) is/are allergic to? Please provide details and management plans, if applicable.

CULTURAL

Cultural Information: _____
Principal Language spoken at home: _____
Relevant Culture details i.e., foods, activities,
etc.: _____

PHOTOGRAPHY PERMISSION

Do you allow for photographs of your child to be taken and used by the program for promotion of the centre? Yes No

MOVIES

On some occasions we watch movies or TV. The movies we watch are rated G and PG. They are selected for their suitability for the children attending the program at that time. By signing the enrolment form, you are allowing your child(ren) to watch the chosen films and TV shows.

I, the undersigned approve of the enrolment and agree to abide by the rules and conditions of the Outside School Hours Program and meet any costs incurred. I authorize the Coordinator in the event of any unforeseen accident or illness to obtain such medical assistance as is required and agree to meet any expenses attached to such treatment.

I also accept full responsibility for my child's belongings whilst attending this program.

I fully understand that if my child continuously misbehaves and after behaviour guidance procedures have been followed, I will be notified and my child may be removed from the program.

I undertake to inform the staff of any absence of my child. I acknowledge that my child will not attend the program if suffering from a contagious disease. In the event that my child is injured or becomes ill during the program, either an authorised person or I shall collect my child as soon as possible.

I understand that all enrolment details are private and confidential. This information will be used for program purposes only and will be accessible to all OSHC staff, Committee of Management and the Principal. I understand that I can access this information and correct any necessary details whenever I wish.

Signed (Parent): _____ Date: _____

Signed (child): _____

Signed (child): _____

Signed (child): _____