

Prescott College Southern
Out of School Hours Care

Enrolment forms



Please complete the following forms and return to the
school or OSHC

Address:

140 Pimpala Road
MORPHETT VALE
SA 5162

Phone:

School: 8381 4290
OSHC: 0450 951 645

Email:

office@prescottsouthern.sa.edu.au

Prescott College Southern Out of School Hours Care Parent/Guardian Agreement

Child participation

I give permission for my child/children to participate in the OSHC program and understand that OSHC staff will notify parents/guardians of each individual excursion.

I understand it is my responsibility to advise staff if I do not wish my child/children to participate in a particular activity.

Child Information

I give permission for OSHC staff to exchange information relating to my child with school staff and to the appropriate person(s) (e.g. in an emergency/special needs of my child/children).

Written permission

I understand that OSHC staff require written permission, for my child/children to travel alone, to and from the OSHC service. I am aware that the Director/Qualified staff will sign my child/children in and out of the service and the arrival and departure times will be noted.

Photo consent

I consent to photographs (still or video) being taken of my child/children, as part of the OSHC program and to be displayed around the OSHC site on display boards and in newsletters.

Work consent

I consent to my child's work being published in an OSHC newsletter and displayed in the OSHC area.

OSHC behaviour Management

The OSHC program has a behaviour management policy in place where the main feature is to recognise and support positive behaviours. I understand that it is the responsibility of the parent to inform the OSHC staff of the child's behaviour needs. (A copy of the behaviour management process is available in the OSHC policy booklet)

Permission to inspect for head lice

The South Australian Health Commission recommends that everyone checks their hair every week for head lice. Checking and treating hair is by law a parent's responsibility. I give permission for OSHC staff to check my child's hair for head lice, if there is a possibility of head lice. I understand any checks will be conducted sensitively.

I understand that I will need to collect my child, if OSHC supervising staff believe that my child has head lice. I understand it is my responsibility to arrange collection of my child from OSHC, when notified. I understand that I may have to provide a letter from a general practitioner to say my child is free of head lice.

Sun protection

OSHC follows the guidelines of the Cancer-Council SA that recommend that children be sun smart and wear hats while outside. I understand that if my child does not have a hat he/she will spend play time in a shaded area. Sun block will be used in accordance with the OSHC policies and procedures.

Fees

I agree to pay the required fees for my child/children booked into care at this OSHC.

Medical emergency

In the event of a medical emergency, OSHC staff will call an ambulance, in line with standard first aid training. I understand that I am responsible for the cost associated with medical care and hospital costs. I understand that I also am responsible for ambulance costs unless my child is a student at Prescott College Southern and covered by their insurance policy.

Privacy Act

I understand the information collected by the centre is for the purpose of registration, program planning, preparing statistics, reporting and evaluation. I accept it may be disclosed to and used by the Commonwealth and State government departments and their agencies. It may also otherwise be disclosed without consent where authorised or required by law.

Information to parents

I have read the OSHC 'Information for Parents' and agree to comply with the OSHC service policies and procedures outlined.

Parent/Guardian.....

Date.....



Enrolment Form Out of School Hours Care

Please supply the following information regarding your child.

STUDENT INFORMATION

Name of child:

Surname: _____

Christian Names: _____

Home address:

Street: _____

Suburb: _____ Post code: _____

Telephone: _____

Is this a silent number? Yes/No

Birthday:

Date of birth: _____ Country of birth: _____

Language first spoken: _____

School:

Name of school attending: _____

FAMILY INFORMATION

FATHER:

Name: _____

Occupation: _____

Home address: _____

Telephone (home): _____ (work) _____ (mobile) _____

MOTHER:

Name: _____

Occupation: _____

Home address: _____

Telephone (home): _____ (work) _____ (mobile) _____

IF DIVORCED/SEPARATED

The child currently lives with: Mother/Father

Are there any Family Court Orders? Yes/No
(If yes please attach a copy of the order)

Are there any restraining orders in relation to the child? Yes/No
(If yes please attach a copy of the order)

ENGLISH AS A SECOND LANGUAGE:

Language spoken at home: _____

Language first spoken by child: _____

Has your child attended an English as a Second Language Unit? Yes/No

Is this student of Aboriginal and Torres Strait Islander Origin?

For person of both Aboriginal and Torres Strait Islander origin, mark both 'yes' boxes

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

DISABILITY

Does your child have a disability that will require the centre to provide additional support? Yes/No
(If yes please attach a copy of the assessment)

FINANCIAL INFORMATION

Do you qualify for Child Care Assistance? Yes/No

If Yes, have you completed the Centrelink Application form? Yes/No

PERSONAL COMMITMENT

1. I agree to support the OSHC centre in collecting my child/children if required due to sickness or inappropriate behaviour at the centre.
2. I agree that payment of the fee account is my responsibility and accounts must be paid within 30 days of receipt of statement. If account is not paid, I agree to pay all expenses incurred by you in pursuing recovery of overdue accounts including legal fees, administrative costs and commission payable to debt recovery consultants.

SIGNATURE: _____

DATE: _____

WITNESS: _____

DATE: _____

Prescott College Southern
Out of School Hours Care – Emergency Contact

This information is confidential and will be available only to supervising staff

Family Name	Family Name	Family Name
Child's Name Preferred Name	Child's Name Preferred name	Child's Name Preferred name
Address	Address	Address
Birth date	Birth date	Birth date
School	School	School

Parent/Guardian information

This information will be used to contact you in an emergency

Parent/Guardian Name	Parent/Guardian Name
Address	Address
Home phone	Home phone
Work Address	Work Address
Work phone	Work phone
Mobile	Mobile

Emergency contacts

If parent/guardians cannot be contacted, emergency contacts will be notified and possibly be asked to collect the child

1. Name	2. Name	3. Name
Address	Address	Address
Phone Mobile	Phone Mobile	Phone Mobile
Relationship to child	Relationship to child	Relationship to child

Other people authorised to collect child/children

If a special arrangement has been made for social/sporting events these people may collect the child/children

Name	Address	Phone
Name	Address	Phone
Name	Address	Phone
Name	Address	Phone

Custody/access

Details of custody issues/restraining orders

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Please note: it is the parent's responsibility to inform the OSHC staff of any relevant and useful information in relation to the child or the family. This allows the OSHC staff to provide informed quality care for your child/children.

MEDICAL INFORMATION

FAMILY NAME:	MEDICARE No:
Given Name:	Date of Birth
Mother's name	Father's Name:
Address:	
Mother's Home Phone Number:	Father's Home Phone Number
Mother's Work Number:	Father's Work Number:
Mother's Mobile Number:	Father's Mobile Number:

Please note Work phone numbers will only be used in a medical emergency.

EMERGENCY CONTACTS

NAME	TELEPHONE

PERSONAL MEDICAL DETAILS

ALLERGIES: YES / NO (please circle)

DETAILS:

MEDICATION: Is any medication to be administered in an emergency? YES / NO (please circle)

DETAILS:

SPECIFIC EMERGENCY PROCEDURES YES / NO (please circle)

DETAILS:

PLEASE NOTE: Attach more specific details if applicable

FAMILY DOCTOR

NAME:	Telephone Number:
Address	

Do you have Private Medical cover? YES / NO (please circle)

If YES state Fund and cover given by the fund.

Do you have Ambulance Cover? YES / NO (please circle)

In the event that you are unconscious or unable to communicate, do you grant permission for the following to take place as deemed necessary? (Tick the appropriate boxes)

Doctor ☐
Anaesthetic ☐

Ambulance ☐

Flinders Medical Centre ☐

Signature: _____

2022



Prescott College Southern OSHC Booking Sheet

Family Name: _____

Name of Children: _____

Booking Type

Permanent/Casual

Day	<input type="checkbox"/> Mon	<input type="checkbox"/> Tues	<input type="checkbox"/> Wed	<input type="checkbox"/> Thurs	<input type="checkbox"/> Fri
Morning session	<input type="checkbox"/> AM	<input type="checkbox"/> AM	<input type="checkbox"/> AM	<input type="checkbox"/> AM	<input type="checkbox"/> AM
Afternoon session	<input type="checkbox"/> PM	<input type="checkbox"/> PM	<input type="checkbox"/> PM	<input type="checkbox"/> PM	<input type="checkbox"/> PM

Signature: _____

Date: _____



OSHC Fees Assistance Application Form

Family Name: _____

Children's Names: _____

Applicants Name: _____

Address: _____

Areas Applying for Discount:

☐ Before School Care

☐ After School Care

☐ Vacation Care

Percentage of Discount Applying for (please mark)

☐10% ☐15% ☐20% ☐25% ☐to be negotiated

Current Child Care Rebate Percentage: _____

OSHC Fee Assistance is available to students from Prescott College Southern whose parents do not qualify for the maximum Child Care Rebate.

Please return this form to:

The Principal

Prescott College Southern

140 Pimpala Road

Morphett Vale

SA 5162

Enquiries: Nigel Peterson phone: 83814290

Email: nigelpeterson@prescottsouthern.sa.edu.au

Privacy Statement of Prescott College Southern

1. Prescott College Southern collects personal information on all families who enrol students in their school. The primary purpose of this information is to enable the school to provide schooling for your child/children.
2. Some of the information we collect is to enable to the school to discharge its duty of care
3. Failure to complete any part of the information requested may have some bearing on how the school is able to respond and meet the individual needs of each student/family. If we do not obtain the information required, we may not be able to enrol or continue the enrolment of your children.
4. Health information about pupils is sensitive information under the privacy act. We ask you to provide medical details about pupils from time to time in order for the school to provide appropriate care of individuals as the need arises. We also ask you to provide emergency contact details. We encourage you to notify doctors and emergency contacts that you are disclosing their information to the school and why, and that they can access that information if they wish.
5. Personal information collected from students is often disclosed to their parents or guardians. Achievements and activities of students are often published in our newsletter, school magazine or other publications.
6. The school from time to time discloses personal information to others for administrative and educational purposes. This includes other schools, government departments, medical practitioners, and people providing services to the school including visiting professionals.
7. Parents may seek access to personal information collected about them and their child/children by contacting the school. If there are items that you consider need updating or correcting, you have the right to request such changes be made. There may be occasions when access is denied. Such occasions would include having an unreasonable impact on the privacy of others or access resulting in a breach of the School's duty of care.

A copy of the Prescott Schools Privacy Policy is available on request

Prescott College Southern OSHC
Enrolment Form: Part 1140 Pimpala Road Morphett Vale 5162
Ph: (08) 8381 4290Fax: (08) 8387 3170
office@prescottsouthern.sa.edu.au

CHILD

Family Name:			Gender:	<input type="checkbox"/> F / <input type="checkbox"/> M
First Name(s):			Known as:	
Date of birth:	___ / ___ / ____	CRN:		
Address				
N.O. / Street		Town/	Suburb:	
Postcode:		Primary Language:		
Indigenous status:	Aboriginal:	Yes / No	TS Islander:	Yes / No

ENROLLING PARENT/GUARDIAN & BILLING DETAILS

Name:				
Date of birth:	___ / ___ / ____	CRN:		
Relationship to child:	Contact <input type="checkbox"/>	Primary Language:		
Address:				
(f) (w)				
Phone:	(f) (w)	(m)		
E-mail:				

IN CARE ELSEWHERE

I am claiming Childcare Benefit at other Approved Childcare Services (which includes LDC, OSHC, FDC, JHC, OCC) for this number of children: ☐

OTHER PARENT/GUARDIAN (if applicable)

Name:				
Relationship to child:	Contact <input type="checkbox"/>	Primary Language:		
Address:				
(f) (w)				
Phone:	(f) (w)	(m)		
E-mail:				

PARENTING PLANS / ORDERS relating to this child

EMERGENCY CONTACTS & COLLECTION AUTHORITIES

Name:		Contact <input type="checkbox"/>
Address:		Priority: <input type="checkbox"/>
Phone:	(f) (w) (m)	Relationship to child:
Name:		Contact <input type="checkbox"/>
Address:		Priority: <input type="checkbox"/>
Phone:	(f) (w) (m)	Relationship to child:
N.B. It is very important that you tell these people that you have nominated them. In nominating them you give them authority to act on the child's behalf if neither parent can be located, to pick up the child in an emergency and care for the child until s/he can be returned home.		

COLLECTION AUTHORITIES ONLY

Name:		Relationship to child:
Address:		Priority: <input type="checkbox"/>
Phone:	(f) (w) (m)	Relationship to child:
Name:		Contact <input type="checkbox"/>
Address:		Priority: <input type="checkbox"/>
Phone:	(f) (w) (m)	Relationship to child:
N.B. The people nominated here have been given approval only to collect the child and should NOT be contacted in case of an emergency.		

Enrolment Form: Part 3

BOOKINGS

BSC	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Arrive							
Depart							
From <input type="text"/> / <input type="text"/> / <input type="text"/>	for: <input type="text"/>			weeks / or until: <input type="text"/> / <input type="text"/> / <input type="text"/>			or Ongoing (tick) <input type="checkbox"/>

ASC	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Arrive							
Depart							
From <input type="text"/> / <input type="text"/> / <input type="text"/>	for: <input type="text"/>			weeks / or until: <input type="text"/> / <input type="text"/> / <input type="text"/>			or Ongoing (tick) <input type="checkbox"/>

VAC	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Arrive							
Depart							
From <input type="text"/> / <input type="text"/> / <input type="text"/>	for: <input type="text"/>			weeks / or until: <input type="text"/> / <input type="text"/> / <input type="text"/>			or Ongoing (tick) <input type="checkbox"/>

IS THERE ANYTHING MORE WE NEED TO KNOW??

(e.g. 1. any personal, religious or cultural practices/prohibitions that you would like the service to know for 2. comments on homework, behaviour management etc.)

CONSENTS

Please initial next to each item to which you consent.

I consent for my child to take part in supervised walking excursions within the local area as part of the Centre's program.	<input type="checkbox"/>
I consent for my child to be photographed and for their image and name to be published in circumstances the Director deems to be appropriate.	<input type="checkbox"/>
I consent for Centre staff to apply sunblock to my child if required.	<input type="checkbox"/>
I consent for Centre staff to apply insect repellent to my child if required.	<input type="checkbox"/>
I give permission for staff of the Centre to administer panadol to my child if the need arises.	<input type="checkbox"/>
I give consent for my child to be taken by a staff member to the local hospital or doctor's surgery in the event of a minor injury.	<input type="checkbox"/>

AGREEMENTS

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

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

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

Parent / Guardian signature: _____

Date: ____/____/____

Interviewed / Accepted by:	sighted a child health record (tick)	
	Date:	/ /