*A parent or guardian who has lawful authority in relation to the child must complete this form. A brief explanation of lawful authority is found at the end of this form. Licensed children’s services may use this form to collect the child’s enrolment information as required in regulations 31 to 35. Questions marked with an asterisk \* are not required by regulations, but you are encouraged to answer these to assist the service in caring for your child.*

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| **INFORMATION ABOUT THE CHILD** | | | | | | | | |
| Family Name |  | | | Given Name | |  | | |
| Date of birth |  | | | Gender | | 🞏 Male 🞎 Female | | |
| Home Address |  | | | | | | | |
| Medicare No |  | | | | | | | |
| Child’s CRN |  | | | | | | | |
| Language used in child’s home | | | |  | | | | |
| Cultural background | *Please Comment:*  \*Is the child of Aboriginal and /or Torres Strait Islander origin? *Please tick*  🞎 No, not Aboriginal or Torres Strait Islander  🞎 Yes, Aboriginal 🞎 Yes, Torres Strait Islander | | | | | | | |
| Any religious/cultural philosophies or beliefs that the BASC need to be aware of? | | | | 🞏 Yes 🞎 No *If yes please comment* | | | | |
| Does this child have a developmental delay or disability including intellectual, sensory or physical impairment? | | | | 🞏 Yes 🞎 No *If yes please comment* | | | | |
| Does this child have any medical conditions or special needs? (Eg asthma – please provide BASC with medication to be kept on site, epilepsy, diabetes etc that are relevant to the care of your child) | | | | 🞏 Yes 🞎 No *If yes please comment and attach Management Plan to be followed with respect to the medical condition* | | | | |
| Does your child have any allergies or sensitivity? | | | | 🞏 Yes 🞎 No *If yes please provide details of any allergies and an management procedure to be followed with respect to the allergy* | | | | |
| Has your child been diagnosed at risk of Anaphylaxis?  Does your child have an auto injection device (eg EpiPen)? | | | | 🞏 Yes 🞎 No *If yes please provide the child’s individual medical management plan signed by the child’s doctor and make an appointment with the Principal and BASC provider to complete a risk management plan for your child. The school will also provide you with their anaphylaxis management policy.*  🞏 Yes 🞎 No *If yes please provide BASC with injection device to be kept on site* | | | | |
| Are there any dietary restrictions for your child? | | | | 🞏 Yes 🞎 No *If yes please comment* | | | | |
| Is your child on any daily medication? | | | | *If yes, please provide details of medication and frequency* | | | | |
| Medical Practitioner name | | |  | | | | | |
| Medical Practitioner Address | | |  | | | | | |
| Medical Practitioner Phone | | |  | | Mobile | | |  |
| Does your child have a health record (health and development assessments and immunisations) | | | 🞏 Yes 🞎 No *If yes, please either attach or provide to service for sighting*  *Name and position on person at the children’s service who has sighted the child’s health and development assessments and immunisations records*  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| INFORMATION ABOUT THE PARENTS OR LEGAL GUARDIANS | | | | | | | | |
| First Name, Middle Name,  Surname | | Date of birth | | | | | | |
| Address – as per child or: | |  | | | | | | |
| Relationship to child | |  | | | | | | |
| Home phone | |  | | | Work | |  | |
| Mobile No | |  | | | CRN | |  | |
| Does the child live with you | | 🞏 Yes 🞎 No | | | | | | |
| Are you – tick one of the following | | 🞏 Parent 🞎 Legal Guardian  🞎 Have parental responsibility for the child under a decision or a court order | | | | | | |
| Cultural background | *Please Comment:*  \*Are you of Aboriginal and /or Torres Strait Islander origin? *Please tick*  🞎 No, not Aboriginal or Torres Strait Islander  🞎 Yes, Aboriginal 🞎 Yes, Torres Strait Islander | | | | | | | |

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| --- | --- | --- | --- | --- |
| Name | |  | | |
| Address – as per child or: | |  | | |
| Relationship to child | |  | | |
| Home phone | |  | Work |  |
| Mobile No | |  | CRN |  |
| Does the child live with you | | 🞏 Yes 🞎 No |  |  |
| Are you – tick one of the following | | 🞏 Parent 🞎 Legal Guardian  🞎 Have parental responsibility for the child under a decision or a court order | | |
| Cultural background | *Please Comment:*  \*Are you of Aboriginal and /or Torres Strait Islander origin? *Please tick*  🞎 No, not Aboriginal or Torres Strait Islander  🞎 Yes, Aboriginal 🞎 Yes, Torres Strait Islander | | | |

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| **COURT ORDERS / PARENTING PLANS** | |
| Please list parenting orders or parenting plans relating to powers, duties, responsibilities or authorities of any person in relation to the child or access to the child.  Please attach court orders relating to the above. | 🞏 This is not applicable to this family  🞎 I have attached  *Comments:* |
| ***Please note:***  ***PARENTING ORDER*** *means a parenting order within the meaning of section 64B(1) of the Family Law Act 1975 (Commonwealth)*  ***PARENTING PLAN*** *means a parenting plan within the meaning of section 63C(1) of the Family Law Act 1975 includes a registered parenting plan within the meaning of section 63C(6) of the Act* | |

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| **CONSENT FOR MEDICAL TREATMENT** | |
| In the event of any illness or accident, I authorise the person in charge to make arrangements for any medical attention / treatment that may be deemed necessary. This may include medical treatment from a registered medical practitioner, hospital or ambulance service. | 🞏 Yes 🞎 No |
| Ambulance Subscriber? | 🞏 Yes 🞎 No |
| Do you give permission for your child to travel in an ambulance if deemed necessary? | 🞏 Yes 🞎 No |

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| **Emergency Contact No 1 (if parents/guardians are not immediately contactable)** | | | |
| Name |  | | |
| Address |  | | |
| Relationship to child |  | | |
| Home phone |  | Work |  |
| Mobile No |  | | |
| Is this person an authorised nominee | 🞏 *is this person authorised to consent to medical treatment of the child or to authorise the administration of medication to the child*  🞎 *is this person authorised to collect child from the BASC service* | | |

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| **Emergency Contact No 2 (if parents/guardians and are not immediately contactable)** | | | |
| Name |  | | |
| Address |  | | |
| Relationship to child |  | | |
| Home phone |  | Work |  |
| Mobile No |  | | |
| Is this person an authorised nominee **Please tick box if YES** | 🞏 *is this person authorised to consent to medical treatment of the child or to authorise the administration of medication to the child*  🞎 *is this person authorised to collect child from the BASC service* | | |

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| **CONSENT TO TAKE PHOTOS** | |
| I give permission for my child’s photograph to be taken and displayed in the BASC facilities. I also agree for photos to be filed for accreditation. | 🞎 Yes 🞎 No |
| I give permission for my child’s photograph to be used outside BASC facilities, e.g. newsletter, newspaper | 🞎 Yes 🞎 No |

|  |  |
| --- | --- |
| **PERSON WHO FILLED OUT ENROLLMENT FORM** | |
| Parent / Guardian name |  |
| Signature |  |
| Date |  |

|  |
| --- |
| **Confidentiality of enrolment records** |
| The proprietor of the children’s service must ensure that information in the child’s enrolment record is not divulged to another person unless necessary for the care or education of the child, to manage medical treatment of the child, where expressly authorised by the parent or prescribed in the Children’s Services Regulations 2009 (regulation 35(1) (d-e) |

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| **BASC ATTENDANCE INFORMATION** | |
| Name of Child |  |
| Day/s your child requires care |  |
| Date commencing program |  |
| Before and After school care | 🞎 Permanent Days Casual Care 🞎 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **BEFORE SCHOOL PROGRAM**  *please tick day/s you require permanent care* | | | | |
| MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
|  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **AFTER SCHOOL PROGRAM**  *please tick day/s you require permanent care* | | | | |
| MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
|  |  |  |  |  |

**I, the undersigned, declare that the above information is true and correct and give permission for my child to attend the Out of School Hour Program and to not hold the Pyalong Primary School Council, or it’s employees responsible for any injury to my child, or for any loss or damage to property that may be incurred during the program.**

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**